UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0003 *
INDEX TITLE: Medical Staff

SUBJECT: Professional Practice Evaluation Policy (Peer Review)
DATE: April 1, 2024

This Policy applies to the following United States based UPMC facilities, including any providers who practice therein:

[Check all that apply]

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center
☒ UPMC Center for Reproductive Endocrinology and Infertility
☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center **(JV)**
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center
☐ West Shore Surgery Center **(JV)**

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

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PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

1. OBJECTIVES AND SCOPE OF POLICY

1.A ***Objectives.*** The primary objectives of the professional practice evaluation ("PPE") process of a Participating UPMC Hospital (the "Hospital") are to:

(1) ***Effective Practitioner-Specific Reviews.*** 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) ***Sharing Lessons Learned.*** 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) ***Addressing System/Process Issue.*** Promote the identification and resolution of system/process issues that may adversely affect the quality and safety of care being provided to patients.

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

(1) This Policy applies to services provided at the Hospital by Practitioners.

(2) 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 performance. 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, the Chairs of the Leadership Council and the Professional Practice Evaluation Committee ("PPEC") will 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 PPEC; or

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

2. STEP-BY-STEP REVIEW PROCESS. This section describes each step in the clinical review process. These steps are illustrated in the Flowchart of Professional Practice Evaluation Process and the PPEC Case Review Guidelines, both of which are included in Appendix A to this Policy.

2.A ***Cases to Be Reviewed.***

(1) ***Specialty-Specific Triggers.*** Each Department will identify adverse outcomes, clinical occurrences, or complications that will trigger PPE. The PPEC will approve these triggers and review them periodically to evaluate their effectiveness.

(2) ***Reported Concerns.*** Any Practitioner or Hospital employee may report to the PPE Specialists Committee concerns related to the safety or quality of care provided to a patient by an individual Practitioner.

(3) ***Other Cases or Issues.*** Cases or issues may be identified for review through any other means, including but not limited to those described in the PPE Manual.

2.B ***Follow-up with Individuals Who Report Concerns.*** The PPE Specialists Committee or Vice President of Medical Affairs ("VPMA") should follow up with individuals who report concerns, either verbally or in writing. A template Response to Reported Concerns is included in the PPE Manual.

2.C ***PPE Specialists Committee.***

(1) ***Document Matter.*** All cases or issues identified for review shall be referred to the PPE Specialists Committee, who will document the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet).

(2) ***Fact-Finding.***

(a) The PPE Specialists Committee will review, as necessary, the medical record, other relevant documentation, and the Practitioner's professional practice evaluation history. The PPE Specialists Committee may also interview and gather information from Hospital employees, Practitioners, and others who may have relevant information.

(b) For any Practitioner-specific concerns that may be referred for review from the serious safety event or sentinel event review processes, interviews and other fact-finding should be coordinated between the two processes, to the extent possible, to avoid redundancy and duplication of effort.

(3) ***Review and Determination.*** The PPE Specialists Committee will consult with the Chair or a member of the appropriate Clinical Specialty Reviewer ("CSR"), the Chair or a member of the PPEC, or VPMA if there is any uncertainty about the proper determination or review process for a case. The PPE Specialists Committee will then:

(a) determine that no further review is required and close the case. The PPE Specialists Committee will provide periodic reports to the PPEC of cases closed pursuant to this subsection. Such reports should include the specialty-specific trigger that caused the case to be identified so the PPEC can evaluate the utility of such triggers. The PPE Specialists Committee may not close cases initiated via a reported concern;

(b) send an Information Letter (see Section 3 of this Policy and the Sample Information Letter in the PPE Manual for additional information on Information Letters); or

(c) determine that further review is required and refer the case after making any necessary preparation (e.g., completing applicable portions of case review form, conducting research, etc.).

(4) ***Referral of Case for Further Review.***

(a) ***Referral to Clinical Specialty Reviewer.*** The PPE Specialists Committee will refer most cases to the appropriate Clinical Specialty Reviewer ("CSR"), except as set forth below.

(b) ***Referrals to Leadership Council.*** The PPE Specialists Committee may refer a clinical case to the Leadership Council if the case involves a concern for which expedited review is needed. Matters involving possible behavioral concerns or Practitioner health issues will be referred for review under the Professionalism Policy or Practitioner Health Policy, respectively.

(c) ***Referrals to the PPEC.***[1]

(i) If a Performance Improvement Plan is currently in effect, the PPE Specialists Committee will consult with the PPEC Chair to determine if the case should be referred directly to the PPEC.

(ii) The Medical Staff President or PPEC Chair, in conjunction with the VPMA, may direct the PPE Specialists Committee to refer a case directly to the PPEC if they determine that the case raises concerns for which direct referral to the PPEC is the most appropriate review process.

(d) ***Referrals Involving Certain Complex Cases.*** If a case involves:

(i) Practitioners from two or more specialties or Departments;

(ii) a member of the CSR who would otherwise be expected to review the case; or

(iii) a matter for which necessary clinical expertise is not available on the Medical Staff,

the PPE Specialists Committee will consult with the PPEC Chair or VPMA regarding the appropriate review process. (See Section 5.A of this Policy for guidance on external reviews.)

(e) ***Referrals under Professionalism Policy.*** If a case involves conduct issues, it should be referred for review under the Professionalism Policy.

[1] For Critical Access Hospitals, the Leadership Council may serve in the role of the PPEC for purposes of this Policy.

(f) ***Referrals under Practitioner Health Policy.*** If a case involves health concerns, it should be referred for review under the Practitioner Health Policy.

(5) ***Reports to PPEC.*** The PPE Specialists Committee will provide periodic reports to the PPEC regarding the determinations and referrals made pursuant to this section.

2.D ***Clinical Specialty Reviewer.***

(1) ***Review.*** When a case is assigned to a CSR (i.e., PPEC Member on behalf of the PPEC or a Department Committee), the CSR conducts the initial review. If the CSR is a Department Committee, a member of the CSR may conduct the initial review of the case on behalf of the CSR and then communicate about the case with the other member(s) of the CSR in reaching a determination. The CSR or PPEC member, as applicable, will complete the CSR Case Review Form (see the PPE Manual).

(2) ***Assistance from Assigned Reviewer.*** The CSR conducting the review may seek assistance from an Assigned Reviewer. The Assigned Reviewer may serve as a consultant or may be asked to complete an AR Case Review Form (see the PPE Manual) and report his or her findings back to the CSR. In all cases, the CSR remains responsible for completing the CSR Case Review Form.

(3) ***Input from Practitioner.*** If a CSR or an Assigned Reviewer has any questions or concerns about the care provided by the Practitioner, the CSR or Assigned Reviewer should obtain input from the Practitioner prior to completing the review. Section 4 of this Policy and the PPE Manual contain additional information on obtaining input from the Practitioner.

(4) ***Determinations.*** CSRs may with the agreement of the PPEC Chair or VPMA (except for referrals to the PPEC):

(a) determine that no further review is required and close the case;

(b) notify the Practitioner of exemplary care;

(c) send an Educational Letter to the Practitioner (see Section 3.C of this Policy for additional guidance and the PPE Manual for a Sample Educational Letter);

(d) conduct or facilitate Collegial Counseling with the Practitioner (see Section 3.C of this Policy and the PPE Manual for a Collegial Counseling Checklist and a Sample Follow-up Letter to Collegial Counseling); or

(e) refer the matter to the PPEC for determination.

2.E ***Professional Practice Evaluation Committee.***[2]

(1) ***Review.*** The PPEC will consider any Case Review Forms, supporting documentation, input obtained from the Practitioner involved, and recommendations for all cases referred to it.

(2) ***Information Sharing with Employer.***

(a) In accordance with the Policy on Sharing Peer Review Information Among UPMC Entities, if the Practitioner involved is employed by the Hospital, the PPEC may notify an appropriate Hospital representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a Hospital-related entity or private entity that meets the definition of Employer in this Policy, the PPEC may notify a representative of the peer review committee within the Employer and request assistance in addressing the matter.

(b) If the Employer is notified, a representative of the Employer may be invited to attend meetings of the PPEC, participate in discussions and deliberations, and participate in any interventions.

(c) Any information or documentation that may be shared with the Employer will be maintained only in a peer review-protected file at the Hospital or the Employer, and ***not*** maintained in the employment or personnel file of the Practitioner.

(3) ***Input from Practitioner*****.** If the PPEC has any questions or concerns about the care provided by the Practitioner, the PPEC may obtain additional input from the Practitioner beyond what has already been obtained, prior to making any final determinations or findings.

(4) ***UPMC System PPEC.*** The PPEC may at any time refer to the UPMC System PPEC to serve as a resource and to provide assistance when requested.

(5) ***Determinations.*** Based on its review of all information obtained, the PPEC may take one of the following actions:

[2] For Critical Access Hospitals, the Leadership Council may serve in the role of the PPEC for purposes of this Policy.

(a) determine that no further review or action is required and close the case. If information was sought from the Practitioner involved, the Practitioner will be notified of the determination;

(b) notify the Practitioner of exemplary care;

(c) send an Educational Letter;

(d) conduct or facilitate Collegial Counseling;

(e) develop a Performance Improvement Plan (see Section 3.C of this Policy and the PPE Manual for additional guidance on Performance Improvement Plans;

(f) after consultation with the Employer, refer the matter to the Employer for disposition, with a report back to the PPEC regarding the action taken by the Employer. If the PPEC determines the Employer's action is insufficient, the PPEC may make one of the other determinations set forth in this subsection; and

(g) refer the matter to the Medical Executive Committee.

In making its determination, the PPEC may consult the Case Review Guidelines set forth in Appendix A.

2.F ***Leadership Council.*** The Leadership Council is primarily responsible for addressing issues of professional conduct and health in accordance with the Professionalism Policy and the Practitioner Health Policy. However, with respect to clinical performance issues, the Leadership Council may review:

(1) any matter that requires immediate or expedited review given the seriousness of the issue. In such case, the Leadership Council will conduct a preliminary review, take any action necessary to protect patients, commence the process to obtain additional expertise if needed, and refer the case to the CSR or PPEC for review under this Policy; and

(2) any other matter that may be referred to it by the PPEC. For example, the PPEC may ask the Leadership Council to oversee a Performance Improvement Plan that has been developed by the PPEC.

If the individual under review is an Employed Practitioner, the Leadership Council may consult with the Employer in performing these functions. The Leadership Council may also at any time refer to the UPMC System PPEC to serve as a resource and to provide assistance when requested.

2.G ***Time Frames for Review.***

(1) ***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 determination, within 90 days.

(2) ***Assigned Reviewers.*** Assigned Reviewers are expected to either consult with the CSR member, CSR, or PPEC, depending on who requested assistance, or submit a completed AR Case Review Form, if applicable, within 14 calendar days.

(3) ***Clinical Specialty Reviewers.*** A CSR is expected to complete its review within 14 calendar days.

(4) ***External Reviewers.*** If an external review is sought as set forth in Section 5 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.H ***No Further Review Required.*** Cases may be closed according to the process set forth in this Policy if a determination is made that there are no clinical issues or concerns presented in the case that require further review. Documentation of cases that are closed shall be provided to the PPE Specialists Committee, who shall maintain records of closed cases and provide periodic reports to the PPEC. If information was sought from the Practitioner involved, the Practitioner will also be notified of the determination.

2.I ***Exemplary Care.*** If a CSR or the PPEC determines that a Practitioner provided exemplary care in a case under review, the Practitioner should be sent a letter recognizing such efforts.

2.J ***Referral to the Medical Executive Committee.***

(1) ***Referral by the PPEC or the Leadership Council.*** The PPEC (or the Leadership Council, if involved) may refer a matter to the Medical Executive Committee if:

(a) it determines that a Performance Improvement Plan may not be adequate to address the issues identified;

(b) the individual refuses to participate in a Performance Improvement Plan developed by the PPEC;

(c) the Practitioner fails to abide by a Performance Improvement Plan; or

(d) the Practitioner fails to make reasonable and sufficient progress toward completing a Performance Improvement Plan.

(2) ***Pursuant to the Medical Staff Bylaws 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 Medical Executive Committee pursuant to the Medical Staff Bylaws or Credentials Policy or the elimination of any particular step in the Policy when deemed necessary under the circumstances.

3. OPTIONS TO ADDRESS CLINICAL CONCERNS

3.A ***General.*** This Policy and the Case Review Forms in the PPE Manual discourage the use of any scoring or grading of cases. Instead, this Policy focuses on specific efforts to address any issues that may be identified in a constructive and educational manner and thus foster a culture of continuous improvement. Specifically, this Policy encourages the use of Initial Mentoring Efforts and Progressive Steps by Medical Staff Leaders to successfully address questions relating to an individual's clinical practice.

3.B ***Initial Mentoring Efforts.*** Initial Mentoring Efforts may include, but are not limited to, discussions, mentoring, coaching, and sharing of comparative data. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, brief documentation is encouraged to help determine if any pattern may be developing that would recommend a more formal response. Any documentation will be maintained in the Practitioner's confidential file. A Description of Initial Mentoring Efforts and Progressive Steps is included in the PPE Manual.

3.C ***Progressive Steps.*** For matters that are reported to, or identified by, the PPE Specialists Committee and reviewed under the PPE Policy, Medical Staff Leaders will generally use Progressive Steps to address any performance issues that may be identified. Additional information on each of the following Progressive Steps may be found in the PPE Manual.

(1) ***Information Letters.***

(a) Information Letters are intended to make Practitioners aware of an expectation or requirement. They are non-punitive, informational tools to help Practitioners self-correct and improve their performance through timely feedback.

(b) The PPEC will prepare a list of objective occurrences for which an Information Letter will be sent to a Practitioner. The list may be modified by the PPEC at any time, without the need for approval by the Medical Executive Committee or Board.

(c) The PPE Specialists Committee will generate an Information Letter to be sent to a Practitioner upon the occurrence of an event which has been identified ahead of time by the PPEC. The Information Letter will be signed by the PPEC Chair. A Sample Information Letter is included in the PPE Manual.

(2) ***Educational Letters.***

(a) Educational Letters describe the opportunities for improvement that were identified in the care reviewed and offer specific recommendations for future practice. A Sample Educational Letter is included in the PPE Manual.

(b) Educational Letters may be sent by a CSR, with the agreement of the PPEC Chair or VPMA, or by the PPEC.

(c) The PPEC and Department Chair will be informed of the substance of any Educational Letter.

(3) ***Collegial Counseling.***

(a) Collegial Counseling is a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders.

(b) Collegial Counseling shall be followed by a letter that summarizes the discussion and the recommendations and expectations regarding the Practitioner's future practice in the Hospital.

(c) A CSR, with the agreement of the PPEC Chair or VPMA, or the PPEC may decide that Collegial Counseling will be used to address concerns with a Practitioner.

(d) The PPEC and Department Chair will be informed of the substance of any Collegial Counseling and the follow-up letter, regardless of who conducts or facilitates it, and may contact the PPE Specialists Committee to review a copy of the follow-up letter.

(e) A Collegial Counseling Checklist to help prepare for meetings and a Sample Follow-Up Letter to Collegial Counseling are included in the PPE Manual.

(4) ***Performance Improvement Plan*.**

(a) The PPEC may develop a Performance Improvement Plan to bring about sustained improvement in an individual's practice. The PPE Manual provides examples of the elements that may be included in a Performance Improvement Plan. However, a Performance Improvement Plan may include any activity that the PPEC determines will help the Practitioner to improve.

(b) If a Practitioner disagrees with the need for a Performance Improvement Plan developed by the PPEC, the Practitioner is under no obligation to participate in the Performance Improvement Plan. In such case, the PPEC cannot compel the Practitioner to agree with the Performance Improvement Plan. Instead, the PPEC will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Bylaws or Credentials Policy.

3.D ***Documentation*.** Information Letters, Educational Letters, follow-up letters to Collegial Counseling, and Performance Improvement Plan documentation will be placed in the Practitioner's confidential file and considered in the reappointment process.

4. OBTAINING INPUT FROM THE PRACTITIONER

4.A ***Input Required*.** No Educational Letter, Collegial Counseling, or Performance Improvement Plan will be implemented until the Practitioner is first notified of the specific concerns and provides input as described in this Section. Prior notice and a request for input are not required before an Information Letter is sent to a Practitioner.

4.B ***Manner of Providing Input.*** The Practitioner will provide input through a written description and explanation of the care provided, responding to any specific questions posed in writing to the Practitioner. Upon the request of either the Practitioner or the person or committee conducting the review, the Practitioner may also provide input by meeting with appropriate individuals (as determined by the individual or committee conducting the review).

4.C ***Office Records*.** As part of a request for input pursuant to this Policy, the person or committee requesting input may ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office that are relevant to a review being conducted under this Policy. Failure to provide such copies or access will be viewed as a failure to provide requested input.

4.D ***Sharing Identity of Any Individual Reporting a Concern.*** Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter will not be disclosed to the Practitioner unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

4.E ***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 through the Professionalism Policy.

4.F ***Failure to Provide Requested Input or Attend Meeting.***[3]

(1) ***Automatic Relinquishment for Failure to Provide Written Input or Attend Meeting.*** A Practitioner's failure to either: (i) provide written input; or (ii) attend a meeting and discuss issues in good faith, when requested to do so pursuant to this Policy will result in the automatic relinquishment of the Practitioner's clinical privileges, but only if all of the following conditions are satisfied:

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, an Assigned Reviewer, a CSR, the Leadership Council, or the PPEC;

(b) the written request gives the Practitioner a reasonable amount of time (generally five days) to provide the written input or to prepare for the meeting; and

(c) the written request notifies the Practitioner that failure to provide the written input or attend the meeting will result in the automatic relinquishment of clinical privileges pursuant to this Policy.

See the PPE Manual for a sample letter regarding Notice of Automatic Relinquishment Because of Failure to Provide Input.

(2) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If a Practitioner automatically relinquishes clinical privileges pursuant to this Policy and fails to provide the requested written input or meet with the applicable individuals or committee within thirty (30) days of the automatic relinquishment, the Practitioner's Medical

[3] The provisions regarding the automatic relinquishment of clinical privileges for failure to attend a requested meeting or provide requested input shall not apply to Practitioners at a New York hospital. Instead, if a Practitioner at a New York hospital refuses or fails to meet or provide input as requested under this Section, the Practitioner's decision should be documented in the applicable case review and the review will continue as described in this Policy.

Staff membership and clinical privileges will be deemed to have been automatically resigned.

4.G ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Policy are administrative actions that occur by operation of the PPE Policy. They are not matters 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.

5. ADDITIONAL PROVISIONS GOVERNING THE CLINICAL REVIEW PROCESS

5.A ***External Reviews.***

(1) Obtaining an external review is within the discretion of the Leadership Council or PPEC, acting in consultation with the Hospital President or VPMA. No Practitioner has the right to demand that the Hospital obtain an external review in any particular circumstance.

(2) Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with UPMC.

(3) If a decision is made to obtain an external review, the Practitioner involved will 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 or access to the reviewer's report, except that any comments related to care provided by other individuals will be redacted.

(4) 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.

5.B ***System/Process Issues.***

(1) Quality of care and patient safety depend on many factors in addition to Practitioner performance, such as the existence of systems or processes that reduce the likelihood of errors occurring (e.g., time-outs prior to surgery). These factors are referred to as "system/process issues" in this Policy.

(2) If system/process issues that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through a review conducted under this Policy, the PPEC will be notified.

(3) The PPEC will refer the systems/process issue to the appropriate individual or committee for resolution, and will keep the issue on its agenda until it receives notice that the issue has been resolved.

(4) The PPEC will periodically prepare a summary of systems/process issues that have been resolved as a result of reviews conducted under this Policy, and will share that summary with the Medical Staff. Such information will be shared in a manner that does not identify individual Practitioners or pose a legal risk to the Hospital.

5.C ***Peer Learning Sessions/Dissemination of Lessons Learned.*** Peer Learning Sessions and the dissemination of educational information through other mechanisms are integral parts of the PPE/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 confidential manner, consistent with their confidential and privileged status under the state peer review protection law and any other applicable federal or state law. Additional guidance on Peer Learning Sessions is included in the PPE Manual.

5.D ***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 managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(2) ***Verbal Communications.*** Telephone and in-person conversations should 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).

(3) ***E-mail.*** 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. All e-mails should include a standard convention, such as "Secure: Confidential PPE/Peer Review Communication" in the subject line. All participants in the PPE process are strongly encouraged to use their Hospital e-mail accounts to maximize peer review and HIPAA privacy protections. E-mail may also be sent to non-Hospital accounts when: (i) the e-mail merely directs recipients to check their Hospital e-mail, or (ii) the e-mail is encrypted in a manner approved by Hospital policy. Any e-mail

containing a patient's protected health information must comply with the Hospital's HIPAA policies.

(4) ***Risk Management.*** Information that is generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities.

(5) ***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 should sign an appropriate Confidentiality Agreement. Any breaches of confidentiality by Practitioners will be reviewed under the Medical Staff Professionalism Policy. Breaches of confidentiality by Hospital employees will be referred to human resources. The PPE Manual includes Confidentiality Agreements that may be used to implement this subsection.

(6) ***Practitioner Under Review.*** The Practitioner under review must also maintain all information related to the review in a strictly confidential manner, as required by state 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.

5.E ***Supervising Physicians and Advanced Practice Professionals and Allied Health Professionals.*** Except as noted below, a physician who has a supervisory or collaborative relationship with an Advanced Practice Professional or Allied Health Professional for state licensure purposes shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving the Advanced Practice Professional or Allied Health Professional. Without limiting the foregoing, the primary supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional or Allied Health Professional is sent under this Policy and may be invited to participate in any meetings or interventions. The primary supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the primary supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

5.F ***Delegation of Functions.***

(1) The PPEC is responsible for the peer review and quality assurance processes described in this Policy, subject to the oversight of the Medical Executive Committee and Board. To promote a prompt and effective review process,

the PPEC hereby expressly delegates to the PPE Specialists Committee, Assigned Reviewers, CSR members, Medical Staff Leaders, and the VPMA the authority to perform the functions described in this Policy on behalf of the PPEC. Actions taken by these individuals will be reported to and reviewed by the PPEC as set forth in this Policy.

(2) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Hospital management, by a Medical Staff member, 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. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(3) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

5.G ***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 or the Medical Staff or the Hospital shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(2) Practitioners may not create an audio or video recording of a meeting nor may they broadcast it in any manner (e.g., via live streaming). If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room. Medical Staff Leaders or Hospital personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

5.H ***Professional Practice Evaluation Reports.***

(1) ***Practitioner PPE History Reports.*** A Practitioner history report showing all cases that have been reviewed for a Practitioner within the past two years and their dispositions should be generated for each Practitioner for consideration and evaluation by the appropriate Department Committee and the Credentials Committee in the reappointment process. A Sample Practitioner History Report is included in the PPE Manual.

(2) ***Reports to Medical Executive Committee, Medical Staff, and Board.*** The PPEC should prepare reports periodically that provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases, including numbers of cases closed at each level of the process; listing of education initiatives based on reviews; listing of system issues identified). These reports may be disseminated to the Medical Executive Committee, all Practitioners at the Hospital, and the Board for the purposes of reinforcing the primary objectives outlined in Section 1.A of this Policy and permitting appropriate oversight. A sample PPE Activity Summary Report to be Provided to All Practitioners, MEC, and Board is included in the PPE Manual.

5.I ***Conflicts of Interest.*** 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 PPEC 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 Bylaws, Credentials Policy or other applicable policy will 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 B.

5.J ***PPE Manual.*** Forms, checklists, template letters and other documents that assist with the implementation of this Policy are collectively known as the Professional Practice Evaluation Manual ("PPE Manual"). Such documents will be developed and maintained by the PPE Specialists Committee. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary. However, failure to use such a document does not affect the validity of a review.

5.K ***Substantial Compliance.*** While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

5.L ***Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions.***

(1) At any point in the review process described in this Policy, the Leadership Council or PPEC, or their representatives, may ask a Practitioner to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, Medical Staff Leaders and the Practitioner may also agree upon practice conditions that will protect the Practitioner, patients, and staff during the review process.

(2) These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

5.M ***Definitions.*** Unless otherwise indicated below, the terms used in this Policy are defined in the Medical Staff Credentials Policy.

(1) ***"Assigned Reviewer"*** means a Practitioner, or an individual who has been granted clinical privileges at another entity affiliated with UPMC, who is requested by a CSR member, a CSR, the Leadership Council, or the PPEC to either: (i) serve as a consultant and assist performing the review; or (ii) conduct a review, document his/her clinical findings on the AR Case Review Form, submit the form to the individual or 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 CSR, the Leadership Council or the PPEC.

(2) ***"Clinical Specialty Reviewer"*** or ***"CSR"*** means either (1) a member of the PPEC who is acting on behalf of the full committee; or (2) a Department Committee. CSRs receive cases for review, obtain input from Assigned Reviewers as needed, complete the CSR Case Review Form, and make a determination as described in Section 2.D of this Policy.

(3) ***"Employed Practitioner"*** means a Practitioner who is employed by an Employer.

(4) ***"Employer"*** means:

(a) the Hospital; or

(b) a UPMC-related entity or a private entity that:

(i) has a formal peer review process and an established peer review committee; and

(ii) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

(5) ***"PPE Specialists Committee"*** means a member of the PPE Specialists Committee at a Participating UPMC Hospital. This may include, but is not limited to, a Quality Department RN Reviewer, VPMA, applicable Department Chair, representatives from Medical Staff Services, and/or representatives of the Wolff Center who work on behalf of the Participating UPMC Hospital.

6. AMENDMENTS

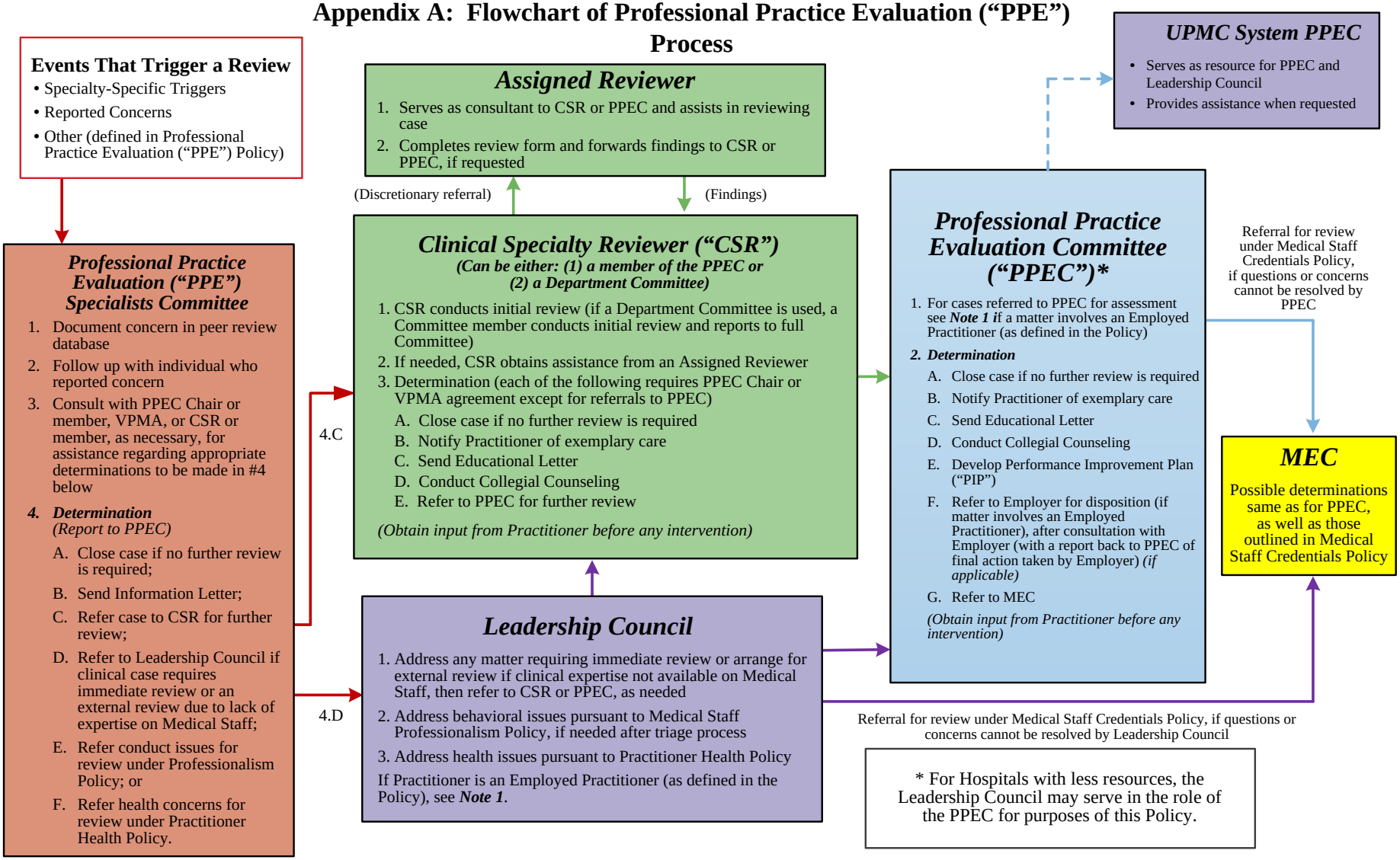
(a) The Medical Staffs and Board at each Participating UPMC Hospital have independently adopted this Policy as their own by voting to approve it for use at each of their respective facilities. In doing so, the Participating UPMC Hospitals have delegated to the Medical Review Council the authority to develop and adopt amendments to this Policy.

(b) Notice of any amendments will be provided to the Medical Executive Committees at each Participating UPMC Hospital for their information. Any amendments to this Policy will take effect immediately upon receiving notice of the changes from the Medical Review Council.

(c) If any Medical Executive Committee has concerns about an amendment, it may bring the concern to the attention of the Medical Review Council. The Medical Executive Committee may also recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

UPMC HOSPITALS

Appendix A: Flowchart of Professional Practice Evaluation ("PPE") Process



SYSTEM ISSUES identified at any level shall be referred to the appropriate person/committee and reported to PPEC, which shall monitor the issue until resolved.

A CSR, the Leadership Council, or the PPEC may refer a case for review during a PEER LEARNING SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual Practitioner has been completed.

Note 1: If the Practitioner is employed by the Hospital ("Employer"), the Leadership Council or PPEC may notify a Hospital representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a qualifying UPMC-related entity or a qualifying private entity (as defined in the Policy), the Leadership Council or PPEC may notify a representative of the peer review committee within the Employer and request assistance in addressing the matter. In all these situations, a representative of the Employer may be invited to attend meetings of the Leadership Council or PPEC, participate in deliberations, and participate in interventions.

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts		Levels of Participation							
	Provide Information	Committee Member						Hearing Panel	Board
		CSR	Credentials Committee	Leadership Council	PPEC	MEC	Investigating Committee		
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	R	R	R	N	N	R
Relevant treatment relationship	Y	R	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 ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y ("Yes, with infrequent but occasional limitations") – 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 CSRs, the Credentials Committee, the Leadership Council, and the PPEC have no disciplinary authority.

In addition, the Chair of each of these committees 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 ("No") – means the Interested Member should not serve in the indicated role.

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

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 Medical Executive Committee 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.

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**