The policies and procedures regarding interprofessional conflict.

OO16: The following policies and procedures are examples of policies and procedures that address identification and management of problems related to interprofessional conflict.

- Policy and Procedure MA:0002: Chain of Command ([Attachment 1])
- Policy and Procedure HR: 6.5: Rules of Conduct ([Attachment 2])
- Medical Staff Professional Practice Manual ([Attachment 3], p. 7: 2.8.3; p.8: 2.8.4; and p. 23)
- Policy and Procedure MSS:023: Addressing Behaviors that Undermine a Culture of Safety ([Attachment 4])
# Title: Chain of Command

**Originating Source:** Patient Safety Team

**Executive Approvals:**
- President and Chief Executive Officer: Al Maghazehe, PhD, FACHE
- President, Medical Staff: Marc S. Whitman, MD
- VP, Medical Affairs: Robert J. Remstein, DO, MBA
- VP, Patient Services/CNO: Patricia Cavanaugh, RN, MSN
- VP, Clinical Services: Linda Dite, RN, MSN, MBA
- VP, QRM/Chief Patient Safety Officer: Molly Sullivan, RN, MA, CPHQ
- VP, Support Services: Greg D'Adamo, FACHE

**Personnel:** Clinical Staff

**DISTRIBUTION:**
- CHMCH
- Administrative Manual

**Effective Date:** November, 2011

**Supercedes:**
- August, 2011 ADM:MA:0002

**Committee Approvals:**
- 06/16/11 Patient Safety Team
- 07/12/11 Medical Executive Committee

**Distribution:**
- CHMCH
- Administrative Manual
- Page: 1 of 5
I. PURPOSE:
Effective communication amongst the healthcare team is critical to support a culture of patient safety. Conversely, ineffective communication is associated with adverse outcomes, increased length of stay, and decreased satisfaction. The chain of command is a course of action involving administrative and clinical lines of authority that is in place to facilitate conflict resolution in patient care situations. It is used only in times when there is no other recourse. Effective chain of command facilitates, rather than impedes, communication, collaboration, and teamwork between the decision maker and the frontline clinician. Chain of command provides healthcare staff with a formal process to use when attempting to get satisfactory resolution on the questionable patient conditions or care delivery. Differences in professional knowledge and skill levels, as well as differences of opinion, can contribute to patient care conflicts between physicians and hospital staff. While the physician bears the responsibility for medical decision making, other members of the healthcare team, such as nurses, respiratory therapist, pharmacist etc. have a duty of care that includes advocacy for the patient.

This document provides guidelines for using the Chain of Command to address clinical, administrative, and safety issues and breakdowns in communication pertaining to the provision of patient care, patient safety, or delays in treatment. Examples include but are not limited to:

- When a physician’s orders remain unclear after the ordering physician is asked for clarification
- In instances where a member of the healthcare team has not responded in a timely manner to an important clinical concern
- When nurse’s assessment of the patient varies significantly from physician’s assessment
- In situations where impairments of a practitioner (this can include physicians, nurses or other healthcare professionals, for example: CRNA) is suspected
- In clinical situations where the nurse believes that a member of the healthcare team has not responded in a manner to fully address the issues raised that may present an immediate risk to the patient
- When questions or concerns arise regarding issues of consent (for example: operative consent)

II. POLICY:
Any member of the healthcare team who has a question about the management of patient care should first contact the attending physician to discuss the concern. If the issue remains unresolved, the team member has the responsibility to initiate the Chain of Command. This applies to all employees, contract personnel, agency personnel, and all practitioners with clinical privileges.

III. PROCEDURE: To Initiate the Chain of Command
A. When a concern arises regarding patient care, the clinical team member should first report the issue to their immediate supervisor (Some examples of clinical team members are: Staff Nurse, Nurse Managers, Department Director, and Respiratory Therapist). If the immediate supervisor is unavailable please follow the departmental policy for notifying immediate supervisor on off shift or contact Nursing Supervisor. If the issue remains unresolved, the clinical team member should follow the Chain of Command below.
B. The steps in the Chain of Command for each unit/department service is:
   1. Staff of the unit/department service/clinic involved
   2. Supervisor/Manager/Charge Nurse on duty
   3. Manager of unit/department service/clinic
   4. Department Director
   5. Vice-President of the Service/Administrator on Call
   6. Executive Vice President
   7. CEO
   8. In the absence of the above listed team members, the Administrative Coordinator would call the Administrator on Call.

See Addendum A for algorithm.

C. If the concern is of an urgent nature and it has not been satisfactorily resolved, or the physician cannot be reached in a timely fashion, the immediate supervisor (or Administrative Coordinator in the absence of the immediate supervisor) must be notified immediately. The Administrative Coordinator is available during all non-business hours. If a message is left for the physician, initiate the chain of command. In urgent matters leaving an unanswered message is not adequate.

D. The immediate supervisor/Administrative Coordinator will contact the physician directly to resolve the issue.

E. If at anytime the concern has not been satisfactorily resolved or the physician cannot be reached in a timely fashion, the appropriate department head may be notified. The Administrator on Call should be notified after the department head, when the department(s) is closed, i.e. 3 to 11, 11 to 7 shifts, weekends, holidays.

F. After discussion with the department head and/or Administrator on Call, the immediate supervisor (or Administrative Coordinator in the absence of the supervisor) will contact the Vice President of Medical Affairs to discuss the issue. In the absence of the Vice President of Medical Affairs, and in concurrence with the Department Head/Administrator on Call, the appropriate Department Chair or Section Chief may be contacted.

G. The Department Head involved (or Administrative Coordinator in the absence of the Department Head or Administrator on Call) is responsible for notifying the appropriate Vice President of the concern as well as the resolution of the problem.

H. All steps taken for the clinical issue will be documented on the patient record. Medical record documentation should include patient assessments and observations, along with the date, time, the names of individuals contacted, any orders received and carried out, and other factual information.

I. Employees who know, or reasonably should know, of an instance of a clinical/administrative/safety issue and/or breakdown in communication pertaining to the provision patient care or delay in treatment and do not implement this Chain of Command Policy to address the issue, may be subject to disciplinary action under Capital Health’s Progressive Disciplinary Action System.
J. Capital Health does not permit retaliatory actions to be taken against individuals who make good faith use of the Chain of Command to address patient care issues.

Anyone who engages in retaliation against an individual for use of the Chain of Command Policy will be subject to appropriate disciplinary action.

Individuals who believe that they have suffered retaliatory action as a result of their use of the Chain of Command should report the suspected retaliation to the Chief Compliance Officer within 48 hours of becoming aware of the retaliation.

The following are some techniques for nurses or other healthcare professionals to use when communicating with physicians to help convey the need for specific patient care actions:

Know which physician to call--attending or surgeon that covers the patient or the unit involved.

When placing calls during the night, ensure that the physician is fully awake before giving critical information and insist on verbal responses that confirm that the physician understands there is a high-risk situation. Follow the read-back teaching approach.

Make clear all telephone communication with the physician. State exactly what action or intervention is being sought--for example, "The patient is bleeding and you need to come in now." Being prepared avoids having to search for the "right words" or "story" to convince the physician of the urgent nature of the call.

If the physician responds by asking questions about assessments, treatments, vital signs or other parameters, the caregiver should not take it as an attack on competency--the physician may just be trying to more deeply understand the situation at hand.

Have all pertinent patient information (e.g., vital signs, assessments) available, and keep the medical record close at hand.

Document exactly what information was relayed to the physician and when, what orders were received in response, and when these actions took place.

IV. REFERENCES:
Garza M, supra note 21.
The Joint Commission. 2011 Hospital Accreditation Standards.
Addendum A

Staff member has concern in relation to a patient’s treatment or care. Staff member can be from nursing unit or from a clinical department. Ex: Cardiology

Physician notified and agreement reached on treatment/care

Unable to resolve treatment/care

Supervisor on Duty/Charge

Nurse notifies physician. Agreement reached for treatment/care.

Supervisor on Duty/Charge

Unable to resolve concern – Nurse Mgr of Unit/Director of Dept. notified (for ex: Director Cardiology). In absence of Nurse Mgr/Dept. Director, Administrative Coordinator can be notified. Admin. Coord. available: 3-11, 11-7, Mon.–Fri; weekends and all holidays: 7-3, 3-11, 11-7.

Nurse Mgr/Dept Director or Adm. Coord. notifies physician. Agreement reached for treatment/care.

Unable to resolve concern – VP of the Service notified. In absence of VP of Service, Admin. on Call notified. Admin on Call available 3-11, 11-7 shifts, weekends, holidays.

VP of Service or Admin. on Call notifies physician. Agreement reached for treatment/care.

Unable to resolve concern, VP Medical Affairs (VPMA) notified. In absence of VPMA and in concurrence with Admin. on Call, the appropriate Dept. Chair or Section Chief notified.

VPMA or Dept. Chair or Section Chief notified, physician agreement reached for treatment/care.

Unable to resolve concern, Exec. Vice President notified.

Unable to resolve concern, CEO notified.
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I. PURPOSE:

To establish behavioral standards for all employees which promote quality patient care, productivity, efficiency, safety, orderly conduct, cooperation among co-workers and positive relations between supervisors and subordinates.

II. FORMS/ATTACHMENTS:

None

III. EQUIPMENT/SUPPLIES:

None

IV. POLICY:

It is the policy of Capital Health (CH) that all employees are expected to comply with the established rules of conduct. These rules are designed to:

A. Protect the interests and rights of all employees, patients, visitors and others on the premises.
B. Promote positive behavior at all levels of the organization by assuring that disruptive behaviors that could contribute to poor patient satisfaction, adverse patient outcomes, or that undermine the CH culture of safety are not tolerated.

Employees who fail to comply with these standards of behavior may be subject to disciplinary action, up to and including discharge (refer to Progressive Discipline Policy HR:6.7 CHMCH).

Although it is not possible to identify every situation which will result in disciplinary action, the following are some, but not all, examples of impermissible conduct and performance which will not be tolerated by Capital Health regardless of position or title:

- Insubordination, failure to follow instructions, policies or procedures
- Compromising patient care, abuse of a patient, or other rude, discourteous behavior
- Refusal or failure to perform assigned tasks, failure to accept work schedule, lack of cooperation
- Repeated failure to complete job assignments
- Unprofessional behavior
- Improper conduct towards supervisor or improper or unprofessional behavior of a supervisor towards an employee
- Fighting, threatening or intimidating other employees, patients or visitors
- Creating an unsafe or unsanitary condition or contributing to such conditions by acts of omission
- Use of profane, abusive, offensive or improper language on CH property or acting in a disrespectful manner
- Threatening, intimidating or coercing any individual
- Verbal outbursts
- Violation of safety regulations
- Unsatisfactory work performance
Neglect of duty, including leaving work area without permission during scheduled work time
Violation or abuse of meal and/or break policy
Smoking and the use of tobacco products on CH owned or leased property
Sleeping or loafing while on duty
Unauthorized personal phone calls or doing other personal business during on-duty hours
Unauthorized use of electronic media (e-mail, internet) for personal reasons
Failure to follow procedures for reporting absence/lateness
Excessive unauthorized non-productive time, including absences, tardiness and leaving early
Failure to maintain current licensure/certification
Violation of CH parking policy
Unsafe motor vehicle operation on CH property or other unsafe CH motor vehicle operation
Violation of dress code
Failure to complete health screening requirements
Failure to attend mandatory in-service
Improper patient identification
Disrupting the work of others
Breach of confidentiality or unauthorized possession, use, copying, or reading of confidential material or disclosure of confidential information to unauthorized persons
Solicitation or acceptance of unauthorized gifts or gratuities from patients, visitors, or vendors
Theft, misappropriation or unauthorized possession or use of property belonging to CH, patients, visitors or other employees
Careless waste of materials or mishandling of supplies or equipment
Damaging, destroying or defacing, through negligence or deliberate acts, property of CH, patients, visitors or other employees
Violation of CH’s non-solicitation policy
Possession, consumption, distribution, transfer, sale, purchase, or manufacture of drugs, alcohol, or other chemical substances on CH property, or reporting to work under the influence of drugs and/or alcohol
Possession, consumption distribution, transfer, sale, purchase or manufacture of controlled substances on non-working time to the extent such use impairs an employee’s ability to perform his/her job or where such activities affect the reputation of CH with the general public or threatens its integrity
Failure to inform CH within five days of a conviction, guilty plea, or no contest plea for controlled substances-related violations under state or federal law
Indecent, immoral or illegal conduct of any nature
Sexual harassment or creation of a hostile work environment
Gambling or soliciting gambling while on CH property
Carrying or possessing a weapon of any kind while on CH property
Disorderly conduct such as fighting, horseplay, or creating a disturbance while on CH property
Misrepresentation or falsification of employment, time, benefit, medical, or other hospital records
Failure to fully and truthfully disclose all facts related to workers’ compensation, insurance claims and leave requests
Littering
Violation of any rule, regulation, policy or practice of CH or a department of CH
Any other behavior that undermines the CH culture of safety

In addition to violations of these standards, should an employee’s performance, work habits, conduct or behavior become unsatisfactory in the judgment of CH, the employee will be subject to disciplinary
action up to and including discharge. Although CH will attempt to help the employee to correct unsatisfactory performance, work habits, attitude, conduct and behavior prior to discharge, CH reserves the right to discharge employees without cause or notice. Employees have the same right to terminate their employment without cause or notice.

Employees who witness violations in the above standards must report the facts of their observations to their immediate supervisor. If for any reason employees are not comfortable addressing their concerns with their immediate supervisor, they should go to the next level on their chain of command or contact the Director of Human Resources Operations or his designee.

Employees may report and cooperate in the investigation of these events without fear of retribution or retaliation and may request anonymity with regard to their reports and involvement.

V. REFERENCES:

Progressive Discipline Policy HR:6.7 CHMCH
The Joint Commission Standards
SECTION 1. PURPOSE AND GOALS OF CENTRALIZED PEER REVIEW

1.1 Purpose

The Medical Staff Professional Practice Manual (Manual) provides specific policies and procedures governing Medical Staff peer review and related provisions as set forth below. Medical Staff peer review (Peer Review) is the objective, confidential evaluation of the quality of a Practitioner’s performance by colleagues for the sole purpose of identifying variance(s) from standard of care (Professional Practice Evaluation). The goal of Peer Review is to find opportunities for personal and process improvement. Monitoring and evaluating a Practitioner’s professional performance is a requirement of the Centers of Medicare & Medicaid Services (CMS) and The Joint Commission (TJC), and is the ultimate responsibility of each Department Chairperson. In recognizing that quality medical care is a responsibility of the Practitioner, the Practitioners practicing at the Hospital chartered the Professional Practice Committee (PPC) as a centralized, objective Peer Review Committee. Data is collected on a continuous basis and is provided to the individual Practitioner and the respective Department Chairperson to document Practitioner competence for reappointment.

The purpose of the PPC is to ensure a systematic, fair, and consistent process for data collection and assessment of Professional Practice Evaluation and competence of Practitioners. This centralized body of peers collects objective data according to approved indicators to assess current competence for all dimensions of professional performance as defined by the medical staff. In addition, the Committee advises the Department Chairperson about the management of performance improvement opportunities and identified competence issues.

Any defined term in this manual that is not expressly defined in this Manual shall have the same definition as provided in the Amended and Restated Bylaws of the Medical Staff of Capital Health System, Inc. (the Bylaws).

Notwithstanding any provision in this manual, in any matter in which there is a conflict between a provision of this Manual and the Bylaws, the provisions of the Bylaws shall supersede the conflicting provision in this Manual.

1.2 Goals

1. Improve patient outcomes and assure quality medical care by pursuing and maintaining excellence in practitioner performance;

2. Maintain patient safety using Just Culture to assess behavioral events;

3. Assure the process of professional practice evaluation is clearly defined, objective, fair, transparent, credible, timely and useful; and,

4. Create a culture with a positive approach to Peer Review by recognizing physician excellence, as well as, identifying improvement opportunities.
1.3 Duties

1. To monitor and evaluate the quality of medical care by Practitioners with privileges at the Hospital on an ongoing basis;

2. To apply universal, specialty-specific, organizationally accepted evidence-based standards of medical care to identify performance with opportunity for improvement;

3. To evaluate the performance of Practitioners and provide reports to document current competence;

4. To review data and reports regarding physician performance including occurrence reports;

5. To collaborate with the Department Chairperson to establish Focused Professional Practice Evaluation when a potential physician specific improvement opportunity is identified;

6. To collaborate with the Departments to implement interventions to address identified safety and medical care issues including educational opportunities;

7. To provide the Credentials Committee accurate, timely data including Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation for reappointment; and,

8. To participate in appropriate educational programs provided by the Hospital or Medical Staff to increase knowledge and skills in performing the Committee’s responsibilities.

1.4 Scope

The PPC collects and reviews data for evaluating and improving physician performance. Issues related to tracking physician performance are addressed by the PPC. There are events that are considered outside the Committee’s scope and fall into three categories.

Performance Improvement

1. Specific committees mandated by federal, state or local regulation are encouraged to refer cases for review when physician performance is a potential contributor to an adverse patient outcome.

2. Departmental morbidity and mortality reviews to identify system issues to be addressed including staffing, policies, procedures, environment equipment and other issues identified that may have contributed to an adverse outcome.
Medical Staff Leadership

3. Credentialing and privileging are the responsibility of the Department Chairpersons and the Credentials Committee.

4. Real-time practitioner behavior events within the scope of the Medical Staff Code of Conduct policy are the responsibility of Medical Staff Leadership.

5. All events involving Residents are referred to the Program Director and are addressed through the educational process.

Hospital Operations

6. Routine concurrent aspects of physician resource use are managed through the Case Management Department.

7. The Health Information Management Department addresses health information management systems issues.

8. Events involving the performance of Advanced Practice Nurses are forwarded to the Chief Nursing Officer.

9. Events involving the performance of Physician Assistants are attributed to the Supervising Physician.

SECTION 2. MEDICAL STAFF PROFESSIONAL PRACTICE COMMITTEE (PPC)

2.1 Composition

Membership of the Medical Staff Professional Practice Committee (PPC) consists of at least twelve (12) Members of the Medical Staff who are in good standing, including at least three (3) Members who are experienced leaders. Other Members may be appointed to reflect separate Medical Staff Departments and major clinical specialties. The President of the Medical Staff appoints the Chairperson and Members of the PPC. The Members and Chairperson are appointed for two-year terms with reappointment for additional terms without limit. Any PPC Member, including the Chairperson, may be relieved of membership at the request of the Department Chairperson in consultation with the department members, and approval by the President of the Medical Staff.

2.1.1 The Chairperson must have served on the PPC for two years and is a voting member of the MEC. The Chairperson may be relieved of membership to the
PPC by the members of the MEC holding at least two-thirds of the vote of the MEC.

2.1.2 Voting members consist of a member(s) from each of the following: Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Neurological Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, Radiology, and Surgery.

2.1.3 The Chief Medical Officer (CMO), the Chief Nursing Officer (CNO) and a representative from the Medical Staff Office (Professional Practice Evaluation Coordinator) provide administrative support and requested information/data to the Committee.

2.1.5 The Committee may also invite other Members, including Practitioners and representatives of the Hospital, the Medical Staff and the Board of Directors, at the discretion of the PPC Chairperson.

2.2 Meetings

The PPC meets monthly and at least ten (10) times per year, and more often as needed to perform its assigned functions. The PPC maintains a permanent record of its proceedings and actions, and reports its actions to the MEC. The Chairperson of the PPC is available to present to the Board Quality and Patient Safety Committee.

A quorum of the PPC shall exist when 30% of the Members of each such Committee are present. The recommendation of a majority of the PPC who are present and eligible to vote at a meeting shall be the action of the PPC. Such recommendation shall then be forwarded to the MEC for action by the MEC.

2.3 Reporting

2.3.1 The PPC reports to the MEC monthly.

2.3.2 The PPC reports to the Board Quality and Patient Safety Committee quarterly.

2.3.3 The PPC reports to the Credentials Committee bi-annually and as requested.

2.4 Responsibilities

The PPC is responsible for the following:

2.4.1 Serving as a liaison for quality review issues with the Medical Staff and ensuring compliance with accreditation standards and federal and state licensure requirements;

2.4.2 Serving as a liaison for the Medical Staff Departments on maintenance of OPPE indicators to improve care and outcomes;
2.4.3 Reviewing unexpected patient care management events identified through occurrence reporting, including morbidity and mortality; and

2.4.4 Analyzing trends of clinical practice and making recommendations for improvements through collaboration with the respective Department Chairperson to support educational opportunities to improve knowledge, skills or abilities, as identified.

2.5 Confidentiality

2.5.1 The PPC functions as a peer review committee consistent with applicable federal and state law. All papers, reports, and information obtained by virtue of membership on the PPC become an integral component of the Patient Safety Evaluation System (PSES). A PSES is a collection of facts and data elements surrounding a patient safety event, near miss or unsafe condition/behavior including review and analysis for the purpose of education, improvement, redesign and transformation.

2.5.2 All members of the PPC and attendees at its meetings keep in strict confidence, consistent with the Medical Staff and Hospital confidentiality policies, all papers, reports and other information obtained by virtue of membership on the PPC or participation in its meetings.

2.5.3 All documents are Patient Safety Work Product (PSWP). PSWP includes all data, reports, memoranda, analyses and/or written/oral statements that could improve patient safety, healthcare quality or healthcare outcomes which is privileged and confidential. Professional practice evaluation information is property of the Hospital and maintained with strictest confidence and security. The work product is maintained by the designated agent of the Hospital in locked file cabinets or in secure electronic format. Medical staff peer review information is PSWP and consists of information related to:

- Performance data according to approved discipline-specific indicators for surveillance and prevention;
- The medical staff member’s role in sentinel events, significant incidents or near misses;
- Correspondence to the medical staff member regarding commendations or learning opportunities.

2.5.4 No copies of peer review documents are created and distributed unless authorized by medical staff policy or Bylaws, the Medical Executive Committee, the Board or by mutual agreement between the President of the Medical Staff and the CMO.

2.5.5 Peer review information for a medical staff member is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities at the Hospital. They have access to the
information only to the extent necessary to carry out their assigned responsibilities. The CMO assures that only authorized individuals have access to medical staff members’ files and that the files are reviewed under the supervision of Medical Staff Office staff. The following individuals have access to medical staff member’s peer review information and only for purposes of quality improvement:

- Medical Staff member;
- President & Chief Executive Officer;
- Chief Medical Officer;
- President of the Medical Staff;
- Department Chairperson;
- Credentials Committee;
- Medical Executive Committee;
- Hospital Legal Staff;
- Chairperson of the Hospital Board of Directors.

2.6 Conflict of Interest

2.6.1 A Practitioner requested to perform peer review may have a conflict of interest and may not be able to render an unbiased opinion. An absolute conflict of interest results if the Practitioner were the provider under review.

2.6.2 Relative conflicts of interest result when a member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. This may be due to a Provider’s involvement in the patient’s care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source.

2.6.3 It is the obligation of the individual reviewer to disclose to the PPC the conflict. It is the responsibility of the PPC to determine on a case-by-case basis if a relative conflict is substantial enough to prevent the individual from participating. When a potential relative conflict is identified, the PPC Chairperson is informed in advance and makes the determination if a substantial conflict exists. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during PPC discussions or decisions other than to provide specific information requested as described in the Peer Review Process.

2.7 Medical Staff Responsibilities and Obligations

2.7.1 As a self-governing Medical Staff, it is the Medical Staff’s responsibility and obligation to identify practice trends that may affect quality of care and patient safety.
2.7.2 The Hospital, through the activities of the Medical Staff, contributes to and supports the evaluation of a Practitioner’s professional performance as a component of process improvement.

2.7.3 The Medical Staff defines the circumstances requiring monitoring and evaluation of a Practitioner’s professional performance which includes the focused evaluation process and the ongoing evaluation process.

2.7.4 Through the establishment and communication of Hospital-wide and specialty-specific data, performance is measured and feedback is provided to Practitioners with the intention of improving performance and outcomes.

2.8 Six General Competencies

Medical Staff members granted privileges are expected to demonstrate ongoing, current competency. The dimensions of performance to be measured include the six general competencies, which serve as a framework for monitoring and assessing a Practitioner’s performance.

2.8.1 Medical/Clinical Knowledge: Practitioners are expected to demonstrate medical and clinical knowledge of established and evolving biomedical, clinical and social sciences, including accurate patient diagnosis and treatment, medications, diagnostics and therapeutic procedures.

1. Proficiency in the knowledge of their specialty
2. Evaluating the evolving medical knowledge and appropriately incorporating it into practice

2.8.2 Patient-Centric Care/Procedural Skills: Practitioners are expected to provide patient-centric care within the scope of the Clinical Privileges granted at the Hospital that demonstrates sound clinical judgment and medical decision-making and is appropriate, effective and compassionate for the treatment of disease, promotion of health, prevention of disease and end of life care.

1. Competence in clinical judgment and medical decision making including pain management and end-of-life decisions
2. Competence in diagnosis and management
3. Competence in performing medical, diagnostic and surgical procedures

2.8.3 Professionalism: In compliance with these Bylaws, Practitioners are expected to demonstrate professionalism with prompt responses to patient care needs and consultation requests.

1. Promoting and actively engaging in teamwork
2. Responding promptly to patient care needs and consultation request
3. Complying with Medical Staff Bylaws and adhering to the Medical Staff Code of Conduct

4. Promoting patient-centric care with a respect for patient privacy and autonomy

2.8.4 **Interpersonal and Communication Skills**: Practitioners are expected to demonstrate clear and cordial interpersonal and communication skills utilizing direct Practitioner-to-Practitioner discussions when feasible.

   1. Clear and cordial communication.
   2. Maintaining medical records consistent with the Medical Staff Bylaws.
   3. Request inpatient consultations with a clear reason for consultation using direct physician-to-physician contact as appropriate.

2.8.5 **Practice-Based Learning and Improvement**: Practitioners are expected to use scientific data, evidence and methods for practice-based learning and improvement to investigate, evaluate and improve patient care, including morbidity and mortality.

   1. Making improvements based on areas of opportunity as identified in their OPPE/FPPE.
   2. Use information technology to manage information.

2.8.6 **System-Based Practice**: Practitioners are expected to demonstrate system-based practices coordinating Hospital admissions, assigning patients to the appropriate level of care and discharging patients to the appropriate setting with any needed services.

   1. Coordinating the hospital admission
   2. Assigning the appropriate level of care
   3. Providing timely discharge to the appropriate setting when medically appropriate
   4. Participating in the identification of system errors and patient safety initiatives

2.9 **Alignment with Hospital Values**

2.9.1 The Medical Staff accepts the mission, vision and values of the Hospital and sets expectations to align with those values.

2.9.2 A Peer Review of Practitioner outcomes that do not meet expectations allows for the identification of vulnerable systems, processes and practices that can be improved.

2.9.3 The goals of the Professional Practice Evaluation include the following:
1. Creating a culture with a positive approach to Peer Review by recognizing Practitioner excellence, as well as, identifying improvement opportunities;

2. Providing a linkage with the Hospital quality structure to assure responsiveness to system-wide improvement opportunities identified by the Medical Staff; and

3. Collaborating with the CME Committee by identifying educational content.

SECTION 3. OVERVIEW OF THE PROCEDURES FOR PEER REVIEW

3.1 Goal and Definition

3.1.1 Peer Review includes any and all activities involving efforts to reduce morbidity and mortality or improve patient care and outcomes for the sole purpose of identifying and engaging in education for process improvement. These activities are conducted by various committees of the Medical Staff or committees of the Board, and include the receipt, review, analysis, actions upon and issuance of occurrence reports and quality and utilization review functions.

3.1.2 A peer is a Practitioner who has expertise in the subject matter referenced in the evaluation. The level of subject matter expertise required to provide meaningful evaluation is determined on a case-by-case basis. For evaluations related to general issues that are not specialty-specific, a Practitioner reviews the case of another Practitioner. For specialty-specific clinical issues, such as evaluating the technique of a specialized procedure, a Practitioner who is well trained and competent in that procedure is required to review the case.

3.2 Professional Practice Committee Meeting

3.2.1 The PPC Chairperson provides a report from the MEC and additional information that has been obtained.

3.2.2 The PPC reviews and discusses the “Track and Trend Report” to validate de-identified events. Action is taken to deem the event valid, not valid or request a case review or additional information from the Practitioner.

1. If the event is deemed valid, the PPC Chairperson communicates the decision of the Committee to the physician. The event is recorded to the appropriate indicator on the Practitioner’s OPPE. If the event exceeds the OPPE threshold or there is significant concern for an adverse pattern, the PPC Chairperson discusses this finding with the respective Department Chairperson and presents this finding at the MEC.

2. If the event is deemed not valid, the Practitioner’s name is removed from the event and the event is not recorded on the Practitioner’s OPPE.
3. If the event is unclear and deemed potentially significant, additional information is requested either directly from the Practitioner or by assigning a case review. Additional information is requested by sending a Letter of Inquiry to the Practitioner prior to final Committee determination.

3.2.3 If a Practitioner is requested to be present at a PPC meeting to clarify an issue upon which the Committee must take an action, the Practitioner’s attendance is mandatory. Information is provided to the Practitioner prior to the meeting, including the rationale for the request.

3.2.4 If the PPC deems necessary, it may seek Peer Review assistance from other Committees or individuals inside or outside the Hospital (“Peer Review Committee”). Internal Peer Review Committees include, without limitation, the MEC, all Departments, the Board and all other Committees performing Peer Review functions, conduct or activities.

3.2.5 The PPC supports the Department Chairpersons with advisory management for performance improvement opportunities.

3.3 Types of Evaluation

3.3.1 Chart Review: Closed medical record reviews are performed by medical record staff who review the required elements of the essential documents. For new Practitioners or at the request of the Department Chairperson, the medical record may be reviewed by the Department Chairperson for quality of documentation.

CMS Core Measure abstraction is conducted by a Registered Nurse auditor in the Quality Department. The Professional Practice Evaluation Analyst validates the measure and ensures accurate Practitioner attribution. A list of all CMS Core Measure opportunities is reviewed at the PPC for validation. The Practitioner is notified by letter signed by the PPC Chairperson along with supporting educational documents.

3.3.2 Review of Cases: Cases are reviewed by the PPC after being identified through a variety of sources including, but not limited to, Hospital Serious Events, referral from Medical Staff Department or Committee, indicators designated for case review or to assess patterns or trends identified by the PPC.

Cases are assigned by the Committee Chairperson on a rotating basis to a voting member of the Committee. After a review of the facts including the event, medical record and discussion with the involved Practitioner(s), a Peer Review Worksheet is prepared and submitted to the Professional Practice Evaluation Analyst. At the next meeting, the case is presented. The involved Practitioner may elect to present to the PPC. An open discussion ensues discussing all aspects of the case. The members vote on whether an
opportunity for improvement has been identified. The decision of the Committee is communicated by the Committee Chairperson to the involved Practitioner.

3.3.3 Proctoring: For a Practitioner requesting a diagnostic or therapeutic procedure ("Procedure"), proctoring is required to document familiarity with the Hospital equipment, policies and procedures. The minimum number of directly observed procedures is included with the approval of Clinical Privileges. In accordance with the Medical Staff Policy and Procedure entitled Focused Professional Practice Evaluation, proctors are assigned to the Practitioner. It is the responsibility of the Practitioner under a required proctorship to obtain the necessary supervision for the procedures and to submit the completed documentation signed by the supervising Practitioner.

3.3.4 External Peer Review: If external Peer Review is obtained for the purpose of credentialing, obtaining Clinical Privileges, disciplinary action or other recommendations affecting membership on the Medical Staff or exercise of Clinical Privileges, any report utilized must be in writing and made part of the internal Peer Review process under these Bylaws. The external Peer Review report is also shared with the Practitioner under review, PPC and the MEC.

3.3.5 360 Degree Assessment: Subjective evaluation is used to discuss performance with other team members (colleagues, consulting Practitioners, surgical assistants, nurses, AHPs or administrators) involved in the patient care.

SECTION 4. FOCUSED PROFESSIONAL PRACTICE EVALUATION

4.1 Definition

Focused Professional Practice Evaluation ("FPPE") reflects a time-limited process of data collection to establish current clinical competency which affects the provision of safe, high-quality patient care. Relevant information resulting from the FPPE process is integrated into performance improvement activities, consistent with the Rules, Regulations, Policies and Procedures that are intended to preserve confidentiality and privileged information. The decision to grant or deny a Clinical Privilege or to renew an existing Clinical Privilege is an objective, evidence-based process based on data collected.

4.2 Quality of Care Monitoring

The Credentials Committee, after receiving a recommendation from the Department Chairperson and with the approval of the MEC, defines circumstances which require monitoring and evaluation of the clinical performance of each Practitioner following his initial granting of Clinical Privileges at the Hospital. The Credentials Committee also develops a program by which the quality of care and clinical performance of each Practitioner is monitored, including the identification of problems, the recommendation and implementation of solutions, and appropriate follow-up. Such monitoring may utilize a range of techniques including, but not limited to: chart review, the tracking of
performance monitors/indicators, proctoring, external peer review, simulations, and morbidity and mortality reviews. The Credentials Committee establishes the duration for such focused professional practice evaluation and conditions that indicate the need for performance monitoring. The Credentials Committee provides summary reports of such activities to the MEC for review.

4.3 **Criteria for Conducting Performance Monitoring**

The FPPE is implemented for new Practitioners, for Practitioners requesting new Clinical Privileges and to evaluate more closely the performance of a Practitioner with an opportunity for improvement in patient care. The FPPE is exclusively educational and is created using a standardized form and objective, defined goals. A Practitioner is measured using the six general competencies.

4.4 **New Medical Staff Members**

4.4.1 All new Practitioners are assigned a FPPE by the Credentials Committee using tiered levels consistent with requested Clinical Privileges, training and experience.

4.4.2 The Credentials Committee defines and assigns a FPPE to a new Practitioner.

4.5 **Medical Staff Requesting New Clinical Privileges**

4.5.1 Practitioners requesting new Clinical Privileges are assigned a FPPE by the Credentials Committee consistent with the requirements of new Practitioners.

4.5.2 It is the responsibility of the requesting Practitioner to provide documentation of the successful completion of requisite education and training.

4.5.3 When Procedures are requested, proctorship is assigned for a defined number of Procedures.

4.5.4 In the event that the Procedure is new to the Hospital, the process must be fair, balanced and educational and an external proctor may be approved after temporary Clinical Privileges are granted to such external proctor.

4.5.5 Depending on the data collected, the initial time period of the evaluation may be extended or the type of evaluation may be changed to allow for documentation of competence.

4.5.6 The FPPE must be completed by the Department Chairperson prior to the Practitioner performing the Procedure independently.

4.6 **Medical Staff with Issues Affecting Patient Care**

4.6.1 The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a Practitioner’s current clinical
competence, practice behavior and ability to perform the requested Clinical Privileges. The outcome of such evaluation may be the development of an education plan for the Practitioner, which results from certain triggers.

4.6.2 A trigger may be a single egregious case, as judged by the President of the Medical Staff, CMO and Department Chairperson, or evidence of a clinical practice trend with the inability to maintain approved Medical Staff indicator thresholds at or above those thresholds of the Practitioner’s peers.

4.6.3 After review and active involvement in the development of the education plan with a specific time frame, the Department Chairperson, together with the CMO or PPC Chairperson or President of the Medical Staff as necessary, presents the education plan to the Practitioner, and monitors progress monthly at a minimum.

4.6.4 The education plan identifies the Practitioner, the respective Department and background information on the Practitioner.

4.6.5 Goals and objectives for each of the six general competencies are used to address the identified opportunities for improvement and are followed by teaching and assessment methods.

4.6.6 Teaching methods include education in the form of educational resources, self-learning or on-line modules, group CME, discussions, counseling, proctoring and/or feedback.

4.6.7 Assessment methods include measurement, objective testing, chart review, proctoring and/or 360 Degree Evaluation.

4.6.8 Data collection by the Medical Staff continues during the education plan in accordance with the approved FPPE.

4.6.9 The Department Chairperson coordinates review of the FPPE, communicates progress monthly to the PPC and reports results on completion to the MEC.

4.6.10 When a Practitioner is subject to a FPPE, he/she is not afforded hearing and appeal rights. If the conclusion of the FPPE results in an action plan to limit or change Clinical Privileges, then the Practitioner is afforded hearing and appeal rights, as outlined in Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these Bylaws.

SECTION 5. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

5.1 Definition

5.1.1 Ongoing Professional Practice Evaluation (“OPPE”) is the routine monitoring and evaluation of professional performance for Practitioners with Clinical Privileges, thereby evaluating the strengths and opportunities for a Practitioner.
5.1.2 All Practitioners with a minimum of twenty (20) cases or Procedures over a two (2) year period are provided a confidential report bi-annually to identify potential problems early to allow for correction or improvement. Reports are generated with data collected from January 1 through June 30 for distribution in September, and July 1 through December 31 for distribution in March.

5.1.3 The content and format of the OPPE is standardized across all Departments, with each Department approving indicators unique to the scope of services provided to facilitate the evaluation of each Practitioner’s professional practice.

5.1.4 The OPPE provides the evaluation of a Practitioner’s professional performance and may include opportunities to improve care based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities for improvement of a Practitioner’s performance related to privileges granted. OPPE information is factored into the decision to maintain existing Clinical Privileges, revise Clinical Privileges or to revoke an existing Clinical Privilege prior to or at the time of reappointment.

5.2 Process for Ongoing Professional Practice Evaluation

5.2.1 Medical Staff performance indicators are developed, approved and customized to meet Hospital-wide and specialty-specific expectations to maintain evidence-based standards of patient care.

5.2.2 The respective Department, PPC and MEC approve all performance indicators before data is collected and reported.

5.2.3 Performance indicators are reviewed by the respective Department, PPC and MEC annually for effectiveness; however the addition or deletion of an indicator may be proposed by the Department Chairperson at any time.

5.2.4 Performance indicators approved for measuring Practitioners’ performance are reported in four categories: Clinical Activity Indicators, Universal Medical Staff Indicators, Universal Quality & Patient Safety Indicators and Discipline-Specific Indicators.

5.3 Medical Staff Performance Indicators

5.3.1 **Clinical Activity:** The Clinical Activity documents the volume of clinical activity by a Practitioner, which is required to determine whether the measured indicators hold significance at re-appointment. If the activity is less than five (5) patient encounters in six (6) months, or less than twenty (20) patient encounters in two (2) years, no conclusions can be drawn from the data abstracted due to the low volume.
In addition, utilization data is provided including length of stay, readmission rate and mortality. This data is for information purposes only and is not used for assessing Practitioner competence.

5.3.2 **Universal Medical Staff Indicators:** The Universal Medical Staff Indicators measures performance by all Members of the Medical Staff, regardless of discipline. These indicators are established based upon professional standards of the Hospital to evaluate and reduce morbidity and mortality, improve patient care and safety, and further the advancement of care in the changing healthcare environment. Compliance with medical record expectations, outcomes of peer review with opportunities for improvement, suspensions from the medical staff, validated complaints from staff or patients/families, and non-compliance with Medical Staff Bylaws are examples.

5.3.3 **Universal Quality and Patient Safety Indicators:** Outcomes directly related to Practitioner performance are included in the Universal Quality and Patient Safety Indicators and apply to all members of the medical staff with clinical privileges. Examples include use of medications, use of blood and blood components, major procedural complications, accidental lacerations/puncture, reversal of moderate sedation, sentinel events and patient safety data.

5.3.4 **Discipline-Specific Indicators:** All departments and clinical disciplines participate in the development of discipline-specific indicators to improve care and outcomes. It is the expectation that all departments and clinical disciplines will participate in development of discipline-specific indicators. If a department or discipline fails to provide recommendations, the PPC has the authority to develop and implement appropriate discipline-specific indicators, with the approval of the MEC. It is understood that all databases belong to the medical staff and not individual departments. All data from these sources are shared with the PPC.

Meaningful data that can be evaluated are often difficult to identify for medical and cognitive specialties. The reliable use of evidence-based practice is applied according to clinical privileges: bundled care for Acute Myocardial Infarction, Heart Failure, Pneumonia, Stroke, and SCIP. Other indicators, including discordance, turnaround times and indicators recommended by specialty societies and organizations, are incorporated into the Specialty-Specific Indicators, as appropriate.

5.4 **Types of Indicators**

5.4.1 The PPC will utilize various forms of indicators to document performance.

   1. Rule-based indicators are reported as a number and apply to administrative and/or clinical compliance.
2. Rate-based indicators are reported as a percent and are used to monitor performance differences among physicians using aggregated outcome data and taking into account variations in practice.

3. Review indicators require case reviews.

9.4.2 Goals for each indicator are set as follows:

1. Benchmark: A result which meets or exceeds expectations and reflects consistent application of evidence-based practice. This is the target that all Practitioners should aspire to achieve.

2. Threshold: The minimum acceptable result and should be met if evidence-based practice and compliance with Medical Staff Bylaws are consistently applied.

5.4 Data Collection

Multiple sources of information are used to compile the OPPE including electronic abstraction, which is preferred to ensure consistency and reliability. When Medical Staff performance indicators align with Hospital indicators, the same data is utilized.

5.4.1 Electronic Data Abstraction from Registration/Billing

Clinical activity data is directly downloaded from the registration/billing system. Validity is dependent upon the accuracy of the recording of the Practitioner’s role in each patient encounter. In addition, coded billing data provides the scope of practice performed at the Hospital.

5.4.2 Electronic Data Abstraction from Occurrence Reporting System

All occurrences entered in the electronic reporting system as a Practitioner Peer Review entry are reviewed by the PPC. Once an occurrence is deemed to be defined as a Medical Staff indicator and the Committee reviews the documented facts, the involved Practitioner is notified of the findings of the Committee. The PPC will review additional information provided by the involved Practitioner that may justify why the occurrence should not be included on the performance evaluation.

5.4.3 Electronic Data Abstraction from Quality Management

Core measures data, publicly reported measures and value-based purchasing measures are entered in the quality management focus study.

5.4.4 Case Review
Complex cases, cases with unanticipated outcomes or cases designated as case reviews are assigned to a PPC Member to review. The review is comprehensive, including a review of the complete medical record and a discussion of the case with the involved Practitioners. The involved Practitioners can, but are not required to, attend the PPC meeting when the case is presented to the Committee. Discussion and disposition of the case is sent to the involved Practitioners with any PPC recommendations.

5.5 Data Review & Evaluation

Data review and evaluation is performed by the Department Chairperson prior to distribution to the Practitioner. The data is confidential, however it is archived in the electronic credentials module biennially at the time of reappointment to the Medical Staff. Evaluation outcomes include:

5.5.1 Exemplary Care: If all indicators demonstrate care above threshold and any of the indicators exceed benchmark, the Practitioner is providing exemplary care. A letter of commendation may be sent to the Practitioner.

5.5.2 High-Level Quality Care: If all indicators demonstrate care performance above threshold, the Practitioner is providing high-level, quality care. A letter of commendation may be sent to the Practitioner.

5.5.3 Potential Opportunity for Improvement: If any of the indicators is within 10% of the threshold, the Practitioner is notified in the cover letter signed by the Department Chairperson of the potential opportunity for improvement. It is the expectation that providing the Practitioner information identifying performance difference from peers will result in self-correction. Assistance is offered to provide any additional requested information or education.

5.5.4 Opportunity for Improvement: If any of the indicators are below threshold, the Practitioner is notified in the cover letter signed by the Department Chairperson of the opportunity for improvement. It is the expectation that providing the Practitioner information identifying performance difference from peers will result in self-correction. Assistance is offered to provide any additional requested information or education. If this approach is not successful over the ensuing 6-month reporting period, a Focused Professional Practice Evaluation is recommended.

5.5.5 The Professional Practice Evaluation Analyst prepares letters referenced in 5.5.1 through 5.5.4 with a customized message to each Practitioner that is signed by the Department Chairperson prior to distribution.

5.6 Review of FPPE and OPPE Reports

5.6.1 The PPC reviews FPPE plans on a monthly basis to review progress toward achieving the goal. Medical Staff indicators are reviewed as needed, but at least
annually, with the respective Department to ensure the data being collected is supporting process improvement efforts.

5.6.2 The respective Department Chairperson reviews the OPPEs for the Department prior to distribution to identify any unexpected data trends. After validating the data, a letter of explanation is prepared personally for each Member with adequate data volume.

5.6.3 The Credentials Committee reviews the OPPEs with each reappointment to assess, if Clinical Privileges can continue unchanged or require modification or revocation. Recommendations of the Credentials Committee are discussed at the MEC.

5.6.4 The MEC reviews recommendations of the Credentials Committee and takes action which may include endorsement, modification or return to Credentials Committee for further review. This recommendation is then forwarded to the Board of Directors.

SECTION 6. PEER REVIEW AND EVALUATION PROCESS

6.1 Overview

All Peer Review undergoes the review and evaluation process. The PPC makes recommendations for education, however the PPC does not invoke corrective or disciplinary action.

6.2 Department Chairperson Action

The Department Chairperson reviews and evaluates data collected for each Practitioner with Clinical Privileges in the respective Department. The Department Chairperson also reviews trends in data to identify process improvement opportunities. The Department Chairperson may recommend modifications to Department-specific indicators, benchmarks, thresholds or a FPPE to further assess the clinical competence of a Practitioner.

6.3 Credentials Committee

At the Credentials Committee meeting, the Department Chairperson’s recommendations are reviewed and, if necessary, action is taken. The recommendation of the Credentials Committee is then forwarded to the MEC.

6.4 Medical Executive Committee

A monthly report from the PPC including business and Peer Review findings is presented to the MEC. Follow-up on FPPEs, results of sentinel events and other focused reviews including the action plan, opportunity for improvement identified from case reviews and de-identified aggregate trends are reported. The recommendation of the MEC is then forwarded to the Board of Directors.
6.5 **Board of Directors**

The Board of Directors reviews the report and recommendations submitted by the MEC.

**Section 7 JUST CULTURE**

7.1 **Principles of a Just Culture**

7.1.1 Safety is a personal and organizational priority.

7.1.2 Respect is shown to all people at every level of the organization.

7.1.3 Flawed systems often contribute to the occurrence of error; therefore, simplification and standardization is promoted to optimize reliability and to manage risk.

7.1.4 Learning and improvement result from the comprehensive review of near misses, adverse events or errors.

7.2 **Characteristics of a Safe and Just Culture**

7.2.1 A safe, just culture promotes a work environment that puts safety first, and a culture where all employees, Practitioners and AHPs embrace patient safety as a personal responsibility and an integral part of daily practice.

7.2.2 All employees, Practitioners and AHPs accept responsibility for the safety of themselves, coworkers, patients and visitors, and work together to minimize harm.

7.2.3 Systems are designed to encourage and foster safe operating principles and ongoing risk assessments with a commitment to patient safety regulations and procedures.

7.3 **Just Culture for the Medical Staff**

7.3.1 The Medical Staff supports safe, quality care and applies skills and knowledge to enhance organizational safety by supporting a just culture. The organized medical staff accepts the mission, vision and values at the Hospital and sets expectations to align with those values. In an effort to meet expectations of providing comprehensive, quality healthcare services which improve and sustain the health status of the residents with integrity, excellence, and compassion, the Medical Staff is committed to making safe choices and partner to re-design a robust healthcare system.
7.3.2 The Medical Staff supports the identification and improvement of flawed systems through the electronic occurrence reporting system or communication with Hospital administration. Engineering safe system design and managing behavioral choices creates a learning culture with open communication and teamwork. A review of outcomes that do not meet expectations allows the identification of vulnerable systems that can be improved through development of a system with reliability. Essential to success are protocols for prevention, diagnosis and treatment at the Hospital. A robust system defines multiple layers of barriers to prevent errors, redundancies to ensure reliability and recovery strategies when errors reach the patient.

7.3.3 The Medical Staff addresses Members who engage in the willful and unjustifiable violation of Rules, Regulations, Policies and Procedures or reckless behaviors that increase the risk of negative outcomes. Human behavior can result in harm, or unanticipated consequences to patients. Behavior can be divided into three categories: human error, at-risk behavior and reckless behavior.

1. Human error is a product of the current system design: no rules exist to prevent a similar error, risk from the behavior is not known, and the behavior was not chosen. This error can be managed through changes in processes, procedures and training. When human error occurs, the Practitioner should be consoled.

2. At-risk behavior is unintentional risk-taking. While a rule exists, the risk was unknown. The behavior was chosen, therefore can be managed through removing incentives for at-risk behavior through education: teaching incentives for healthy behavior. When at-risk behavior leads to harm, the practitioner should be coached and counseled.

3. Reckless behavior is intentional risk-taking. A rule exists, the risk is known and the behavior was chosen. While reckless behavior is rare, it must be managed through remedial measures.

7.3.4 Through CME, the Medical Staff is committed to continuous learning to identify and report unsafe events or conditions through participation in morbidity, mortality and improvement conferences. Education focuses on teamwork and communication. Professional conduct promotes teamwork and communication among healthcare providers. Medical Staff have a leadership role, and active engagement in providing safe quality care is supported.
7.4  Just Culture Assessment for Case Reviews

7.4.1  In an effort to build and maintain a just culture for the Medical Staff, every occurrence report is reviewed and assessed for compliance with the Rules, Regulations, Policies and Procedures to avoid risk. Compliance with the Medical Staff Code of Conduct is assessed.

7.4.2  The PPC incorporates a review of communication and teamwork in all case reviews, correspondence and recommendations.

7.4.3  Special attention is given to the identification and resolution of system flaws to improve processes and prevent future similar events. This results in optimizing reliability and managing risk.

7.4.4  Feedback is encouraged from Practitioners involved in an event, and is reviewed by the PPC with each case review discussion.

7.4.5  Accountability is assessed and tracked over time in an effort to minimize human error and to eliminate at-risk and reckless behavior.

7.4.6  Behaviors that undermine safe patient care are addressed consistently, fairly and equitably.
<table>
<thead>
<tr>
<th>Focused Professional Practice Education Plan</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
</tr>
<tr>
<td><strong>Goals and Competencies</strong></td>
</tr>
<tr>
<td>Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Is expected to:</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>Specific requirements or measurable objectives that align with specific educational experience</td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
</tr>
<tr>
<td><strong>Goals and Competencies</strong></td>
</tr>
<tr>
<td>Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Is expected to:</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>Specific requirements or measurable objectives that align with specific educational experiences</td>
</tr>
<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
</tr>
<tr>
<td><strong>Goals and Competencies</strong></td>
</tr>
<tr>
<td>Demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. Is expected to develop skills and habits to be able to:</td>
</tr>
<tr>
<td>- Identify strengths, deficiencies, and limits in one’s knowledge and expertise</td>
</tr>
<tr>
<td>- Set learning and improvement goals</td>
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<tr>
<td>- Identify and perform appropriate learning activities</td>
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<tr>
<td>- Systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement</td>
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<tr>
<td>- Incorporate formative evaluation and feedback into daily practice</td>
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<tr>
<td>- Locate, appraise and assimilate evidence from scientific studies related to their patients’ health problems</td>
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<tr>
<td>- Use information technology to optimize learning</td>
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<tr>
<td>- Participate in the education of patients, families, students, residents, and other health professionals.</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td>Measurable objective for the competencies chosen</td>
</tr>
<tr>
<td><strong>System-Based Practice</strong></td>
</tr>
<tr>
<td><strong>Goals and Competencies</strong></td>
</tr>
<tr>
<td>Demonstrate awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Is expected to:</td>
</tr>
<tr>
<td>- Work effectively in various health care delivery settings and systems relevant to their clinical specialty</td>
</tr>
<tr>
<td>- Coordinate patient care within the health care system relevant to their clinical specialty</td>
</tr>
</tbody>
</table>
• Incorporate considerations of cost awareness and risk-benefit analysis in patient care
• Advocate for quality patient care and optimal patient care systems
• Work in interprofessional teams to enhance patient safety and improve patient care quality
• Participate in identifying systems errors and in implementing potential systems solutions.

Objectives
Measurable objective for the competencies chosen

Professionalism
Goals and Competencies
Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Is expected to demonstrate:
- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest
- Respect for patient privacy and autonomy
- Accountability to patients, society, and the profession
- Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation

Objectives
Measurable objective for the competencies chosen

Interpersonal and Communication Skills
Goals and Competencies
Demonstrate interpersonal and communication skills that result in the effective exchange of information and teaming with patients, their families, and professional associates. Is expected to:
- Communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds
- Communicate effectively with physicians, other health professionals, and health related agencies
- Work effectively as a member of leader of a health care team or other professional group
- Act in a consultative role to physicians and health professionals
- Maintain comprehensive, timely, and legible medical records

Objectives
Measurable objective for the competencies chosen

Teaching Methods
1. Education including educational resources, self-learning, CME, online, reading
2. Discussions
3. Mentorship
4. Proctorship including level of supervision
5. Feedback

Assessment Method
1. Measurement including goals, volumes, and length of evaluation
2. Testing
3. Chart review
4. Feedback from 360 degree evaluations
5. Order set utilization
6. Event reports

Recommendations of the PPC are as specified above and approved at the <date> meeting
I have reviewed the proposed FPPE and supporting documentation for the above-named applicant and make the following recommendation(s):

<table>
<thead>
<tr>
<th>Chairperson, Professional Practice Committee</th>
<th>Date</th>
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</thead>
</table>

Department Chairperson, <Specify> | Date

Other | Date

I have read the above, understand the expectations, and agree with the Focused Professional Practice Evaluation Education Plan as written. Until further notice, I agree to meet monthly with the Department Chair to discuss progress on this educational program. I understand that I will continue to receive an Ongoing Professional Practice Evaluation bi-annually.

<table>
<thead>
<tr>
<th>&lt;Practitioner&gt;</th>
<th>Date</th>
</tr>
</thead>
</table>
Aggregated Data for Indicators on Ongoing Professional Practice Evaluation

- All indicators meet or exceed threshold
  - Exemplary Care: One or more indicator exceeds benchmark
  - High Quality Care: All indicators exceed threshold

- One or more indicator approaching threshold
  - Potential opportunity for improvement Letter from Department Chair with specific opportunity described

- One or more indicator not achieving threshold
  - Opportunity for Improvement Letter from Department Chair with specific opportunity described

Correction 6 mo

Yes

OPPE

No

Correction 6 mo

FPPE

One or more indicator approaching threshold
- Potential opportunity for improvement Letter from Department Chair with specific opportunity described

Correction 6 mo

Yes

OPPE

No

One or more indicator not achieving threshold
- Opportunity for Improvement Letter from Department Chair with specific opportunity described

Correction 6 mo

No

One or more indicator approaching threshold
- Opportunity for improvement Letter from Department Chair with specific opportunity described

Correction 6 mo

Yes

OPPE

No

Correction 6 mo
Peer Review Process

For Event Reports
- Professional Practice Evaluation Analyst
  - Creates an electronic entry
  - Identifies preliminary approved indicator
  - Notifies physician via e-mail or letter to solicit input
  - Notifies appropriate Department Chair

For Core Measure Abstraction
- RN Auditor
  - Creates an electronic entry
  - Assembles the following:
    - Supporting Medical Record documents
    - Respective order set
    - Evidence-based list of antibiotics
  - Notifies physician via letter with the above to solicit input

Review Indicator
- All preliminary validations submitted to PPC
  - If Rate and Rule indicator, add to monthly aggregated report
  - If Review indicator, PPC representative is assigned to review case

Rate or Rule Indicator

PPC representative
- Reviews materials
- Discusses case with involved physician and invites to come to PPC
- Involved physician and/or PPC representative may request additional reviews through the PPC Chair
- Completes Peer Review Form

Professional Practice Committee
- The PPC representative presents the case including consultant reports and involved physician responses
- Involved physician presents to Committee, as needed
- Open discussion
- PPC determines if case was appropriate or identifies opportunity for improvement
- Appropriate Department Chair invited to attend and may serve as content expert when queried

If Case Review Recommended

Chair, Professional Practice Committee
- Communicates results to physician including any consultant reports
- Communicates results to Department Chair
- Add to OPPE Report

If case has opportunity for improvement, however disagreement occurs:

Dept. Chair appears before PPC if he/she disagrees with decision

If disagreement persists:

MEC
- Department Chair presents the case
- Open discussion
- MEC may request additional reviewer
- MEC determines if care was appropriate or identifies opportunity for improvement
Professional Practice Committee
Case Review Worksheet

Dr. 

DATE: 

As a member of the Professional Practice Committee (PPC) you are asked to review the following case. Please review the chart, discuss the case with the involved Practitioner(s), and complete the completed Case Review Worksheet over the next 2 weeks. Once you have finished, forward your written response to the Professional Practice Evaluation Analyst in the Medical Staff Office.

This case will be discussed at the next PPC meeting on _______________.

Patient Name: 
MR#: 
Date of Admission: 

Involved Physician: 
Contact Information: Pager: Answering Service: Email: 

Case Summary: 

Section 1: ISSUE IDENTIFICATION

Physician Documentation – Does the documentation substantiate the clinical course/treatment?
Is the documentation legible? Is the documentation timely to communicate with the patient care team?

☐ No Issue with physician documentation
☒ There was an issue with physician documentation (briefly describe below)

Physician Medical Knowledge/Patient Care
Consider the diagnosis and treatment in relation to each other. Does the diagnostics and treatment meet the standard of care? Was sound clinical judgment and decision making used in the treatment? Were there any issues with the physician’s technique/skills?

☐ No Issue with the Physician’s Medical Knowledge/Patient Care
☒ There was an issue with the Physician’s Medical Knowledge/Patient Care (briefly describe below)

Interpersonal/Communication Skills
Consider the method of communication with the patient/family as well as other disciplines. Did the physician personally contact consultants? Was communication (written and/or verbal) timely?

☐ No Issue with the Interpersonal/Communication Skills
☒ There was an issue with the Physician’s Interpersonal/Communication Skills (briefly describe below)

Professionalism
Consider the impact of the physician’s behavior on the care of the patient. Did the physician intentionally violate a rule? Did the violation’s benefit outweigh the risk? Did the physician’s behavior meet the requirements of the Bylaws of the Medical Staff?

☐ No Issue with Professionalism
☒ There was an issue with the Physician’s Professionalism (briefly describe below)

System-based Issue/Process

☐ No Issue with System-based Issue/Process
☒ A system-based issue was identified-Briefly describe the opportunity for improvement
• If “No Issue…” is marked on all of the above categories, STOP. There is no need to proceed further.

• If “There was an issue with…” is checked on any of the above categories, proceed to Section 2.

Section 2: REVIEW OF PHYSICIAN CARE

☐ Case Reviewed and Physician Care Deemed Appropriate: Evidence-based care was provided. The case is closed. This will not be tracked and trended and the physician will be notified.

☐ Case Reviewed and Physician Care with Opportunity for Improvement: Alternatives to treatment could have been considered. Continue to Section 3

Section 3: OPPORTUNITIES IDENTIFIED

☐ Minor Opportunity for Improvement:

(Briefly describe the opportunity for improvement)

☐ Major Opportunity for Improvement:

(Briefly describe the opportunity for improvement)

Section 4: PATIENT SAFETY/PATIENT HARM CATEGORIES

☐ Category A: An actual error did not occur. This may represent an unsafe environment.

☐ Category B: An error occurred (omission or commission) but did not reach the patient.

☐ Category C: An error reached the patient, but didn’t cause harm or require intervention to preclude harm or extra monitoring.

☐ Category D: An error reached the patient, did not cause harm but required intervention to preclude harm or extra monitoring.

☐ Category E: Error caused temporary harm; didn’t require initial or prolonged hospitalization.

☐ Category F: Error caused temporary harm; required initial or prolonged hospitalization.

☐ Category G: Error required an intervention necessary to sustain life, but didn’t cause permanent harm.

☐ Category H: Error required an intervention necessary to sustain life, and caused permanent harm or death.

☐ Category I: Used for tracking purposes only. Not related to direct patient care.
05/05/2015  Approved, Professional Practice Committee
06/01/2015  Approved, Bylaws Committee
06/09/2015  Approved, Medical Executive Committee
06/23/2015  Approved, Board of Directors
CAPITAL HEALTH
MEDICAL STAFF POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th>TITLE:</th>
<th>Addressing Behaviors that Undermine a Culture of Safety</th>
<th>NO: MSS.023</th>
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<tr>
<td>ORIGINATING SOURCE:</td>
<td>Bylaws Committee</td>
<td>EFFECTIVE DATE: September 22, 2015</td>
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<tr>
<td>EXECUTIVE APPROVALS:</td>
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<tr>
<td>President &amp; Chief Executive Officer</td>
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<tr>
<td>Al Maghzaehe, Ph.D., FACHE</td>
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<tr>
<td>Chief Medical Officer</td>
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<tr>
<td>Eugene J. McMahon, MD, MBA, FCAP</td>
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<td>President of Medical Staff:</td>
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<td>Clinton H. Ogolo, MD</td>
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<tr>
<td>Chairperson, Bylaws Committee</td>
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<tr>
<td>Carolyn Gaukler, MD</td>
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</tr>
<tr>
<td>PERSONNEL:</td>
<td>Medical Staff and Allied Health Professionals</td>
<td>SUPERSEDES:</td>
</tr>
<tr>
<td>LOCATIONS:</td>
<td>Hopewell Medical Center</td>
<td>MSS.023 (CHMCH) November 6, 2011</td>
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<td></td>
<td>Regional Medical Center</td>
<td>MSS.023 (RMC) November 6, 2011</td>
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<tr>
<td>COMMITTEE APPROVALS:</td>
<td>08/31/2015 Bylaws Committee</td>
<td>Page: 1 of: 3</td>
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<tr>
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<td>09/08/2015 Medical Executive Committee</td>
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<td></td>
<td>09/22/2015 Board of Directors</td>
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<tr>
<td>EXPEDITED APPROVALS:</td>
<td></td>
<td>(If applicable. If not applicable, delete this section)</td>
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</table>
I. PURPOSE:

To establish a process for addressing disruptive or intimidating behavior by members of the medical staff including physicians, dentists, podiatrists and allied health professionals including physician assistants, advanced practice nurses, certified nurse midwives and certified registered nurse first assistants.

II. FORMS/ATTACHMENTS: none

III. EQUIPMENT/SUPPLIES: none

IV. POLICY:

The safe provision of medical care requires collegial communication between all health care workers. Behaviors that are considered intimidating or disruptive can result in poor patient outcomes and foster a hostile work environment. The types of behaviors outlined below constitute behaviors that undermine a culture of safety and are therefore intimidating or disruptive and subject to action under this policy in accordance with the provisions of the Bylaws of the Medical Staff. Such behavior will not be tolerated by the Medical Staff and will be addressed by the procedure defined below.

V. DEFINITIONS:

Disruptive or intimidating behavior can be a single egregious act, or a pattern of actions. Egregious acts are defined as behaviors that would be viewed as outrageous by a reasonable person. Examples of disruptive or intimidating behavior include but are not limited to: profane or disrespectful language, demeaning behavior (for example, referring to hospital staff as “stupid”), sexual comments or innuendo, outbursts of anger, throwing instruments or charts, criticizing hospital staff in front of patients or other staff, malicious comments about another physician’s care, boundary violations with staff or patients, inappropriate chart notes (for example, maliciously criticizing the treatment provided by other caregivers), and unethical or dishonest behavior.

VI. PROCEDURE:

Any act or pattern of actions constituting disruptive or intimidating behavior must be reported to the Chief Medical Officer or the President of the Medical Staff in writing. The report should include a description of the event, date, time and circumstances. The Chief Medical Officer or his designee will investigate and report his findings to the President of the Medical Staff.
Possible actions of the Chief Medical Officer:

1. Complaint found to be without merit, complainant notified and no adverse information in connection with the complaint will be maintained in the affected Practitioner’s file with the Office of the Medical Staff.

2. Complaint found to have merit and referred to the Medical Staff Executive Committee through the President of the Medical Staff for action as per the provisions of the Bylaws of the Medical Staff.

VII. REFERENCES:

Sample Policy from the Greeley Group, “Disruptive Medical Staff Policy”
“Behaviors that undermine a culture of safety” The Joint Commission Sentinel Event Alert, Issue 40, July 9, 2008