SCOPE:
This policy pertains to all practitioners granted clinical privileges through the Medical Staff credentialing process at Research Medical Center (RMC).

PURPOSE:
To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical and advanced practice professionals (APP) staffs, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency and patient care. The focused efforts towards individuals complements, but does not replace ongoing efforts to evaluate and improve performance of practitioners who have been granted clinical privileges.

Goals:
  a. Identify opportunities for practice and performance improvement of individual practitioners. Practitioners are Medical Staff members and Advanced Practice Professionals who practice in the Hospital.
  b. Monitor individual clinical performance and significant trends in performance by analyzing aggregate data and case findings.
  c. Assure that the process for professional practice evaluation is clearly defined, objective, equitable, evidence-based, timely, and useful.
  d. Improve the quality of care provided by individual practitioners.
  e. Provide suggested areas for hospital-wide improvement, addressable by focused project teams and re-engineering efforts.

POLICY:
It is the policy of RMC to comply with statutory and regulatory requirements regarding ongoing professional practice evaluation and focused professional practice evaluation. The Medical Executive Committee (MEC) has the authority for directing activities and participation in FPPE and OPPE, and has delegated oversight of the process to the Credentials Committee. The initial ongoing data review and findings about practitioner practice and performance are evaluated by the appropriate Department Chief with the focus on improvement. These findings will support the credentialing and privileging recommendations that are made by the Credentials Committee, MEC and decisions made by the Board of Trustees. Findings from this process resulting in a recommendation that could adversely impact a practitioner’s appointment or privileges will be forwarded to the MEC for consideration in accordance with appropriate provisions of the Medical Staff Bylaws.

DEFINITIONS:
1. **Focused professional practice evaluation (FPPE)** is a process whereby the medical staff evaluates the competency and professional performance of a practitioner. A period of focused review will be conducted for newly appointed practitioners and current practitioners granted a new privilege. It may also be conducted at the discretion of the Department Chief, Credentials Committee, or MEC for a practitioner who has undesirable patterns or trends of practice or whose performance is in question. If a FPPE review results in an action plan to perform an investigation, the process outlined in the Medical Staff Bylaws will be followed.

2. **Ongoing professional practice evaluation (OPPE)** is a process that allows the medical staff to identify professional practice trends that impact the quality of care and patient safety on an ongoing basis. The program includes:
   
   a. The evaluation of an individual practitioner’s professional performance and includes opportunities to improve care based on recognized standards. It differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner’s performance and competence related to their privileges rather than appraising the quality of care rendered by a group of professionals or by a facility.
   
   b. Uses multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with hospital policies, the Bylaws and Rules and Regulations of the medical staff, clinical standards, and the use of rates compared against established benchmarks or norms.
   
   c. Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

3. **Peer** – A "peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance determines what “practicing in the same profession” means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

4. **External Review** – External professional practice evaluation will take place if deemed appropriate by the Credentials Committee and Medical Executive Committee. Circumstances that could require external professional practice evaluations include, but are not limited to:
   
   a. Cases involving litigation, or the potential for a lawsuit as determined by Risk Management.
   
   b. Ambiguity when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner’s membership or privileges.
   
   c. Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty under
review or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review.

d. New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

e. Miscellaneous issues – for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or Board of Trustees may require external professional practice evaluation in any circumstances deemed appropriate by either body.

FPPE PROCEDURE:

1. FPPE will be initiated in the following instances:
   a. Upon initial appointment;
   b. When a new privilege is requested by an existing practitioner;
   c. When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care. Triggers for this type of review may include important single events, significant staff or patient complaints, trends or patterns that significantly and undesirably vary from established patterns of clinical practice or recognized standards from that of other peers, or when OPPE indicates significant trend/opportunity for improvement.

2. A recommendation of FPPE for cause may be made by:
   a. Department Chief or Section Chair
   b. Credentials Committee
   c. Medical Executive Committee
   d. Board of Trustees

3. The FPPE monitoring plan for a new practitioner, or newly requested privilege(s) will be specific to the requested privileges or group of privileges. FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to the bylaws provisions related to investigations.

4. An FPPE monitoring plan that has been implemented due to performance concerns will be based on specific criteria and will have a defined duration of monitoring. Monitoring plans will be established by the appropriate Department Chief in conjunction with the Credentials Committee, and the practitioner will be informed of the expectations of performance.

5. Methods for conducting FPPE may be accomplished by one or more of the following:
   a. Chart reviews, both concurrent and/or retrospective
POLICY TITLE: Focused and Ongoing Professional Practice Evaluation Policy & Procedure

INITIATING DEPT/COMM: Credentials Committee

APPROVAL BODY: Medical Executive Committee

REPLACES POLICY DATED: MS-CR-001-2011

APPROVAL DATE: 07/2013

REVISED: 12/2014

EFFECTIVE DATE: 08/01/2013

REFERENCE NUMBER: MS-CR-001-2013

b. Simulation

c. Discussion with the involved practitioner and/or other individuals involved in the care of the practitioner’s patients

d. Direct observation/proctoring

e. For dependent APP’s, FPPE methods may include review or proctoring by the sponsoring physician.

f. Internal or external peer review.

6. The period of FPPE must be time-limited, which may be defined as a specific period of time or a specific number of procedures/admissions. Each department will be responsible for determining the monitoring parameters for their members and should take into account the practitioner’s previous training and experience in determining the approach, extent, and time frame of FPPE needed to confirm current competence in the privileges they have been granted.

7. FPPE should optimally be completed within three months, or a suitable period based upon volume. The period of FPPE may be extended as necessary at the discretion of the department chief, but may not extend beyond the first biennial reappointment.

8. At the conclusion of the initial FPPE, findings will be presented to the Credentials Committee for a recommendation. Recommendations may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending to limit or suspend the privilege. Such recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to Article 7 of the Medical Staff Bylaws will apply.

9. At the conclusion of a FPPE monitoring plan for performance concerns, recommendations of the Department Chief and Credentials Committee will be reported to the MEC and may include elevation to OPPE, extending the period of FPPE, or recommending to limit or suspend the privilege(s). Such recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to Article 7 of the Medical Staff Bylaws will apply.

10. Each practitioner will be notified of their performance and outcome(s) following conclusion of a FPPE monitoring period, and if any actions other than moving to OPPE are indicated, they will be informed of the specific requirements that need to be met and the method for follow-up to ensure that the concerns have been addressed.

11. At the end of the period of focused evaluation, in the event that the practitioner’s activity/volume at RMC has not been sufficient to meet the requirements of FPPE, the practitioner may voluntarily resign the relevant privilege(s), or, if the practitioner has sufficient volume of the privileges in question at another local facility, external peer
references specific to the privileges held at RMC will be obtained as the method of complying with FPPE standards.

12. The practitioner is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished.

13. Results of FPPE are maintained in the Practitioner’s Confidential Quality File.

**OPPE PROCEDURE:**

1. Every 6 months, the Medical Staff will conduct a performance review of all current members of the medical staff utilizing performance indicators established by each Medical Staff Department and approved by the Medical Executive Committee. Each practitioner will be reviewed in the following areas as appropriate:
   a. Patient care (Examples: complication rates, mortality)
   b. Medical knowledge (Example(s): risk/peer review)
   c. Interpersonal and communication skills (Example(s): patient satisfaction)
   d. Professionalism (Example(s): medical record compliance)
   e. Practice based learning and improvement (Example(s): core measures)
   f. System-based practice (Example(s): length of stay, readmissions)

2. The information used in the OPPE may be acquired through one or more of the following methods:
   a. Periodic chart review
   b. Direct observation
   c. Monitoring of diagnostic and treatment techniques
   d. Discussion with other individuals with direct knowledge of the practitioner’s practice patterns and clinical/technical expertise.

3. It is the responsibility of each Department to identify and approve the professional and clinical indicators that will be tracked for members of their department. General indicators may include the following:
   a. Patient Activity
   b. Core Measures
   c. SCIP Measures
   d. Complication rates
   e. Infection rates
   f. Mortality rates
   g. Individual peer review cases with adverse determinations
   h. Referrals to the Physician Health & Conduct Committee
   i. Patient/Family/Staff written positive feedback
   j. Medical record deficiencies
k. Readmissions for the same issue
l. Returns to surgery
m. Blood usage
n. Pharmacy interventions
o. Patterns of unnecessary diagnostic testing/treatments

4. In addition to the general indicators listed above, measures that are specialty-specific and evidence-based will be developed by each department. Clinical indicators may change as deemed appropriate by the department and approved by the MEC.

5. The Medical Staff Office will initiate data requests for all practitioners with clinical privileges prior to OPPE being submitted to the appropriate Department Chief for review and recommendation.

6. At each six month review, the Medical Staff Office will review all of the approved indicators in comparison to defined targets and flag the elements for specific review by the Medical Staff Department Chief or Representative.

7. **If insufficient clinical performance data, defined as at least 5 patient contacts during a review period, is not available on a practitioner, the Medical Staff Office will generate a no RMC clinical data OPPE profile and will pursue data from other sources, such as a peer with direct knowledge of the practitioner’s current clinical competence, designate them as a “low volume” provider. The medical staff is obligated to collect data for OPPE specific to performance at RMC. Any information received from another organization can only be used as supplemental information and not in lieu of collecting organization specific data or evaluating performance at RMC. At each review point, the Credentials Committee, MEC and BOT will use the data, however limited, to determine whether to continue, limit, or revoke any existing privileges. If at the two year reappointment it is determined that the practitioner has insufficient specific quality data on which to base a recommendation for continued clinical privileges, then the Medical Staff must obtain and evaluate peer recommendations from external sources.**

8. The Medical Staff Department Chief or Representative will document pertinent findings and recommendations on the review form to include:
   a. Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety. If no issues are identified the Department Chief may recommend that the practitioner undergo routine review at their next six-month OPPE cycle.
   b. In the event that a recommendation is made for additional review based on an identified issue, information gathered for the purpose of the review may include, but not be limited to:
      - Drill down reports
      - Additional performance of a specific procedure
POLICY TITLE: Focused and Ongoing Professional Practice Evaluation Policy & Procedure

INITIATING DEPT/COMM: Credentials Committee

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- Additional monthly review
- Direct observation
- Concurrent monitoring
- Retrospective chart review
- Discussion with other individuals involved in the care of the practitioner’s patients

9. This review process will continue until the Medical Staff Department Chief or Representative is either:
   a. Satisfied with the information received and review, or
   b. Recommendations are made to the Credentials Committee for a focused professional practice Evaluation.

10. Each practitioner will be notified of their performance and the outcomes of the review.

11. The information gained by the review of the above information will be confidentially maintained by the Medical Staff Office and incorporated into the two-year reappointment process.

REFERENCES: The Joint Commission; MS.08.03.01 – MS.08.03.09