FACILITY: St. Joseph's Hospital	**MANUAL(S):** Medical Staff
TITLE: Focused Professional Practice Evaluation (FPPE) & Ongoing Professional Practice Evaluation (OPPE) Policy	**ORIGINATING DEPARTMENT:** Medical Staff
SUPERCEDES: I.D.05 **Original: 6/09** **Reviewed: 01/09, 7/12, 6/14** **Revised: 9/12, 7/17**	**POLICY NUMBER:** N/A

I. POLICY:

The St. Joseph's Hospital Medical Staff is organized to monitor and evaluate the quality and safety of care and treatment provided. Collection and evaluation of data related to the exercise of practitioners' clinical privileges will be utilized to improve care and in decisions to continue, limit or revoke clinical privileges.

II. PURPOSE:

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care. The focused efforts towards individuals complements but does not replace ongoing efforts to evaluate and improve performance of clinical groups and enterprise-based systems of care.

III. DEFINITIONS:

A. Focused Professional Practice Evaluation (FPPE): FPPE is a process whereby the Medical Staff evaluates the competency and professional practice of the practitioner.
   a. FPPE is used to confirm current competency of practitioners initially granted privileges and those granted new privileges.
   b. FPPE is used when questions arise regarding a currently privileged practitioner's ability to provide safe, quality patient care.

B. Ongoing Professional Practice Evaluation (OPPE): OPPE is a program applied to all practitioners granted privileges that allows the medical staff to identify professional practice trends that impact 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 system.
   b. The use of multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with hospital policies, the Rules and Regulations and the Bylaws of the medical staff, clinical standards, and the use of rates compared against established benchmarks or norms.

c. Individual evaluation 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.

C. General Competencies: There are six areas of general competencies. These general competencies were developed by the Accreditation Council for graduate Medical education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative and adopted by the Joint Commission. The areas of general competencies include:

a. Interpersonal Communication – Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
b. Patient Care – Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
c. Practice-based Learning – Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
d. Medical Knowledge – Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
e. Professionalism – Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society. (The Joint Commission considers diversity to include race, culture, gender, religion, ethnic background, sexual preference, mental capacity, and physical disability.)
f. Systems-Based Practice – Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

IV. GUIDELINES/PROCEDURES:

A. Focused Professional Practice Evaluation (FPPE):

a. <u>Oversight:</u>
i. Direct oversight of the FPPE process is delegated by the Medical Executive Committee (MEC) to the Credentials Committee of the Medical Staff.
ii. At the end of FPPE or at any time during the FPPE period when the proctor has identified significant competency concerns, the proctor shall immediately inform the Department Chair and/or Credentials Committee Chair.
iii. The Department Chair shall review the results of proctoring and provide a summary to the Credentials Committee that shall include one or more of the following:
(a) Whether the FPPE review findings are adequate to assess the practitioner's current competence, practice behavior and ability to perform the requested new or increased privileges in a safe, high quality manner.
(b) Make recommendation that the FPPE process has been satisfactorily completed and can be terminated for the practitioner.

(c) Make recommendation that the duration, measures, or any portion of the initial FPPE process be extended or revised to require additional monitoring if competency concerns were identified or if insufficient data/cases were available for completion of FPPE.

b. Initiation of FPPE:

i. Circumstances in which FPPE will be initiated include but are not limited to:

(a) A new appointee is initially granted privileges.
(b) Recognition of a pattern of performance with significant negative deviation from that of the peer group detected in routine performance measurement.
(c) Repeated significant patient care related complaints related to clinical care, judgment or decision-making.
(d) Granting of new privileges not previously held by the practitioner.
(e) Investigation of possible practitioner impairment due to physical, psychiatric or emotional condition.
(f) FPPE may be initiated at the recommendation of the Performance Review Committee (PRC) as described in the Medical Staff Peer Review Policy.

c. Duration of FPPE

i. FPPE shall begin when the practitioner is informed of appointment to the medical/allied health professional staff. Newly granted privileges shall be considered under FPPE for a specific period of time or for a specific number of patients/procedures based on the specialty recommendation to the Credentials Committee and the Credentials Committee determination for non-specialty specific general competency issues. The Credentials Committee may alter the time or number of patients/procedures as needed.
ii. The initial proctoring period may be extended if either initial concerns are raised that require further evaluation or there is insufficient activity during the initial period.
iii. Evaluation following granting of new privileges to a practitioner will continue until the specified FPPE is completed and evaluation is deemed adequate by the Credentials Committee.
iv. A practitioner's previous experience may be taken into account in determining the approach and extent of FPPE needed to confirm competency.

d. Criteria:

i. Criteria for FPPE may be applicable to all and should also include measures that are specialty-specific and evidence-based.
ii. Criteria for FPPE when triggered by an unacceptable level of performance will be clearly defined and specific to the privilege(s) in question.
iii. The criteria used for FPPE when privileges are initially granted will be recommended by the individual departments of the organized medical staff and approved by the Credentials Committee and MEC.
iv. Criteria are contained in medical staff department specific FPPE requirements for new appointees and privilege criteria for additional privileges granted to current appointees.

e. Sources of Data:

i. FPPE data can be obtained for all dimensions of practitioner competence from multiple data sources. Data may be individual case specific or rate data from multiple cases. Data may be derived from information specifically obtained for FPPE or for OPPE and may include:
   (a) Direct observation/personal interaction by/with the proctor
   (b) Simulation
   (c) Detailed medical record review by the proctor
   (d) Interviews of hospital colleagues interacting with the practitioner
   (e) Surveys of hospital colleagues interacting with the practitioner
   (f) Chart audits by non-medical staff personnel based on medical staff defined criteria for initial appointees

ii. Source(s) of data for FPPE when triggered by an unacceptable level of performance will be based on the triggering issue.

iii. Evaluations and performance data will be reviewed initially by the respective Department Chair or designee then forwarded to the Credentials Committee with any review notations or comments from Department Chair or designee.

iv. The Credentials Committee will determine if evaluation is adequate or identify additional review or consideration as required.

f. Proctoring Methods:

i. Proctoring may utilize a combination of the following methods to obtain the best understanding of the care provided by the practitioner:
   (a) Prospective Proctoring: Presentation of cases with planned treatment outlined for the proctor's treatment concurrence, review of case documentation for treatment concurrence or completion of a written or oral examination or case simulation.
   (b) Concurrent Proctoring: Direct observation of the procedure being performed or medical management either through observation of practitioner interactions with patients and hospital colleagues or review of clinical history and physical and review of treatment orders during the patients hospital stay.
   (c) Retrospective Evaluation: Review of the case record after care has been completed. May also involve interviews of personnel directly involved in the care of the patient.

g. Proctor's Role:

i. The proctor's role is typically that of an evaluator, not a consultant or mentor.

ii. A practitioner serving as a proctor for the purpose of assessing and reporting on the competence of another practitioner is an agent of the hospital.

iii. The proctor shall receive no compensation directly or indirectly from any patient for this service, and shall have no duty to the patient to intervene if the care provided by the proctored practitioner appears to be deficient. However, the proctor is expected to report immediately to the appropriate Department Chair or hospital authority any concerns regarding the care being rendered by the proctored practitioner that has the potential for imminent patient harm.

iv. The proctor, or any other practitioner, may render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any practitioner who is

subjected to a claim or suit arising out of his or her acts or omissions in the role of proctor.

h. Monitoring by an External Source:
   i. Review and evaluation by an external source may be necessary on occasion. Need for external review may be determined by the Credentials Committee or MEC. An external review may by appropriate if:
      (a) There are ambiguous or conflicting findings by internal reviewers.
      (b) The clinical expertise needed to conduct an evaluation is not available on the medical staff.
      (c) An external evaluation is advisable to prevent allegations of bias, even if unfounded.

B. Ongoing Professional Practice Evaluation (OPPE):

a. Criteria:
   i. The criteria used for OPPE will be recommended by the individual departments of the organized medical staff.
   ii. The Department Chair or designee shall be responsible for the oversight and development of the OPPE criteria for all applicants or staff members assigned to the department.
   iii. Measures of practitioner performance will be selected to reflect the six General Competencies, will be specialty-specific, and include general measures that apply to all Medical Staff.
   iv. Performance measures/triggers may be the result of single or multiple case reviews or rate or rule indicators and may include but are not limited to:
      (a) Review of operative and other clinical procedure(s) performed and their outcomes
      (b) Pattern of blood and pharmaceutical usage
      (c) Unexpected unfavorable patient care outcome
      (d) Unfavorable trends or variations
      (e) Significant variation from accepted standards of clinical performance
      (f) Length of stay patterns
      (g) Morbidity and mortality data
      (h) Practitioner's use of consultants
      (i) Other relevant criteria as determined by the organized medical staff
   v. Measures of practitioner performance will have defined ranges of acceptable performance which may be determined but are not limited to cohort comparisons, national/regional benchmarks, Medical Staff Bylaws, Rules and Regulations and/or policies.
   vi. The Peer Review Committee of the Medical Staff will review criteria and approve as recommended by the individual departments. If not approved, the Department Chair will be consulted with identified issues, and a mutual resolution of criteria will be developed. In cases where no resolution can be achieved in a timely manner, the issue will be referred to the Medical Executive Committee (MEC) for further action and resolution as indicated.
      (a) The information used in the OPPE may be acquired through the following:
         - Chart review or medical record data abstraction

- Proctoring – concurrent, prospective or retrospective
- Monitoring of clinical practice patterns
- External Peer Review/Peer Review
- Reports of professional conduct/behavior
- Case discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

b. Oversight:

i. Direct oversight of the monitoring and evaluation process is delegated by the MEC to the PRC of the Medical Staff. The responsibilities of the PRC related to peer review are described in the peer review policy and Medical Staff Bylaws and Policies.

ii. Individual practitioner evaluations will be provided to the involved practitioner on a routine basis, not to exceed nine (9) months.

iii. Individual practitioner-specific evaluations will be provided by the Quality Resources Department to the Department Chair or designee on a routine basis, in the same frequency and rotation as to individual practitioners in the department.

iv. Evaluations will be reviewed by the respective Department Chair or designee. If no concerns or issues are identified, evidence will be noted that the review occurred (date and signature). Practitioners evidencing patterns of variation, or identified concerns from the Department Chair or designee are referred in a timely manner to the PRC, with a recommendation for additional review, education, collegial intervention or the need for consideration for FPPE, and any relevant review notations or comments from the Department Chair.

v. The PRC will review the recommendation from the Department Chair and confirm if there is a need for additional review, education, collegial intervention or the need for consideration for FPPE.

vi. Any additional intervention or review will be documented and a follow-up reported to the PRC.

vii. The PRC will provide an annual report of OPPE activity and interventions to the MEC for those practitioners requiring additional actions or interventions in response to OPPE criteria variances.

c. Use of OPPE at Reappointment:

i. The Medical Staff uses practitioner-specific OPPE results in making its recommendation regarding the credentialing and privileging process, and as appropriate, its performance improvement activities. This occurs in accordance with existing policies and procedures defined with the Medical Staff Bylaws and Peer Review Policy.

ii. At the time of reappointment, the Department Chair or designee will review the most current 24 months of OPPE data.

iii. If the results of OPPE indicate a potential issue with practitioner performance, the Credentials Committee, PRC, MEC or Department Chair/designee may initiate FPPE.

iv. In addition, a single serious or egregious case may also initiate FPPE.

V. DOCUMENTATION:

1. The hospital will keep provider-specific OPPE/FPPE and other quality information concerning a practitioner in a secure paper/electronic file. Provider-specific OPPE/FPPE information consists of information related to:
    a. Performance data for all dimensions of performance measured for that individual practitioner.
    b. The individual practitioner's role in high risk events, significant incidents or near misses.
    c. Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action.

2. Peer review information in a practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Chief Physician Executive (CPE) will assure that only authorized individuals have access to individual provider quality files and that files are reviewed under the supervision of the Director of Medical Staff Office or designee for the following individuals:
    a. The specific provider
    b. Members of the MEC and/or department chairs, credentials committee
    c. CPE, medical staff services professionals and quality staff supporting the peer review process
    d. Individuals surveying for accrediting bodies with appropriate jurisdiction e.g. The Joint Commission, HFAP, DNV or state/federal regulatory bodies
    e. Individuals with a legitimate purpose for access as determined by the hospital Board of Trustees
    f. The hospital CEO for purposes of any potential professional review action as defined by the medical staff bylaws

3. No copies of OPPE/FPPE documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, or the Board of Directors.