POLICY: Focused Professional Practice Evaluation (FPPE) / Ongoing Professional Practice Evaluation (OPPE)  
POLICY #: MS 1  
CATEGORIY: Medical Staff  
EFFECTIVE: June 2010  
ISSUED BY: Medical Executive Committee  
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APPROVED BY: Board of Managers  
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I. PURPOSE

To define the process by which the medical staff monitors, evaluates and reports the quality of patient care provided by members of the Medical/AHP (Allied Health Practitioner) staff and to identify opportunities for improvement, improve performance and outcomes of care on an individual and organization-wide basis, and take appropriate privilege action when necessary. This policy is an addendum to the Medical Staff Bylaws/Rules Regulations of the facility.

II. DEFINITIONS

A. Medical Executive Committee (MEC): The Medical Executive Committee is described in the Medical Staff Bylaws.

B. Performance Improvement Plan (PI Plan): Performance Improvement Plan serves as the Quality Management Plan of the facility.

C. Focused Professional Practice Review (FPPE): The process whereby the organization evaluates the privilege-specific competence of the practitioner:
   1. When a practitioner does not have documented evidence of competently performing the requested privilege at the organization:
   2. When a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care.

   TJC Standard MS.08.01.01 states: “The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.”

D. Ongoing Professional Practice Review (OPPE): A semi-annual periodic performance review will be done for all current staff utilizing established performance indicators. TJC Standard ADD MS 08.01.03: “The Ongoing Professional Practice Evaluation allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff.” This information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal or to institute a FPPE.”

III. AUTHORITY AND RESPONSIBILITY

The medical staff and governing body of the facility have the authority and responsibility to monitor and evaluate the quality of patient care through organizational and medical staff quality improvement activities. The medical staff has a leadership role in organizational improvement activities designed to ensure that the findings of the assessment process are relevant to an individual’s performance. The medical staff is responsible for determining the use of information in the ongoing and focused professional practice evaluation process of an individual granted clinical privileges. The MEC, as described in the Medical Staff Bylaws, will monitor the overall quality process.
IV. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A. New Privileges: A period of focused review will be conducted for:
   - ALL newly appointed practitioners
   - All existing practitioners who have been granted NEW privileges.

1. The FPPE plan will be practitioner specific. It should include the general elements described for OPPE as well as the specialty-specific indicators identified and any special medical privilege criteria for those privileges, which he/she has been granted.

2. One or more of the following elements will be utilized for each privilege:
   a. Outcomes
   b. Complications
   c. Quality of documentation
   d. Unplanned ACTs

3. Methods for evaluation may include:
   a. Chart review
   b. Direct observation
   c. Statistical review
   d. Proctoring

4. Observation Time Period: will be for the first three (3) months and/or until five (5) procedures have been evaluated. If fewer than five (5) procedures or less than six (6) admissions have occurred during the three (3) months, the observation period will be extended.

5. Final Decision: The results of any negative evaluations will be conveyed to the practitioner as required by the Medical Staff Bylaws.

6. If there is insufficient activity to fulfill the requirements of FPPE, it will be considered that the practitioner has voluntarily relinquished his/her privilege(s).

B. “Problem” Privileges:

1. FPPE will be initiated, upon recommendation of the MEC, in the following circumstances:
   a. By absolute levels, trends, or patterns that significantly and undesirably vary from established patterns of clinical practice, recognized standards or from that of other peers.
   b. Significant single event, staff or patient complaint.
   c. When the results of an organizational improvement activity or medical staff monitoring function identify a significant deviation from accepted standards of practice.
   d. Adverse or negative performance trend over six (6) consecutive months of OPPE.
   e. Repeated failure to follow hospital or medical staff policy (e.g. failure/late to consult, failure to respond to pages, refusing to allow read-back, etc.)

2. The MEC (or one of its subcommittees) will consider the following issues a “trigger” to begin the process of considering conducting a focused evaluation (these events may not necessarily result in a focused evaluation):
   a. incident report on a physician
   b. outlier report at MEC or one of it’s subcommittees
   c. notice from regulatory agency
   d. informal oral report from staff

FPPE will be initiated if the MEC feels that the circumstances suggest the possibility of a threat to patient safety or well being. The need for the FPPE will be conveyed to the practitioner by the Chairperson of the MEC or his/her designee.
3. When FPPE (for “problem) privileges has been initiated:
   a. Method for establishing a monitoring plan:
      - The plan for focused evaluation will be developed by a three (3) person subcommittee of the MEC, which should include at least one member with the same specialty as the practitioner to be evaluated.
      - Final approval of the plan must be given by the MEC.
      - The elements of the plan will vary according to circumstance, but will be both retrospective and prospective;
        - in the case of an interventional:
          - review of all available records for the prior six months specific to the procedure.
          - monitoring of all similar procedures prospectively to include indications, direct monitoring during the procedure, and concurrent monitoring following the procedure.
        - in the case of a more general competency:
          - review of all admissions for the preceding three (3) months.
          - concurrent review of all admissions/consultations performed by the practitioner from the start of FPPE.
      - Reviews will be conducted in-house unless it is determined that an outside evaluation is required.
      - The review period should not exceed fifteen (15) days.
      - At the completion of the review, a determination will be made concerning continuation of privileges or request for corrective action. The recommendation will be made to the MEC. If a serious threat to patient welfare is discovered, the corrective action process should immediately be initiated.
   b. The decision to assign a period of performance monitoring is based on the practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege – other existing privileges in good standing should not be affected by this decision.

V. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

A. The medical staff will conduct periodic performance reviews of all current Medical/AHP staff utilizing performance indicators established in this plan. Specific special medical privilege criteria will be utilized as applicable. OPPE allows the organization to identify individual professional practice trends that impact on quality of care and patient safety and is factored into the decision to maintain existing privilege(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal.

B. The information used in the OPPE may be acquired through one of the following:
   1. periodic chart review
   2. direct observation
   3. monitoring of diagnostic and treatment techniques
   4. discussion with other individuals involved in the care of each patient including consulting physicians, nursing and administrative personnel.

Relevant information obtained from the OPPE is integrated into PI activities, while preserving confidentiality.

If there is uncertainty regarding the practitioner’s performance, the organized medical staff should follow the course of action defined in the medical staff bylaws for further evaluation of the practitioner.

C. The process for OPPE includes the following:
   1. A clearly defined process that facilitates the evaluation of each practitioner’s professional practice defined above.
   2. The type of data to be collected is determined by the individual departments. Joint Commission regulations list the following elements, which should be reviewed.
**CLINICAL PERFORMANCE**

- Medical assessment and treatment of patients
- Adverse privileging decisions
- Use of medications
- Use of blood and blood components
- Other procedures
  - appropriateness (judgment)
  - outcomes (clinical and technical skill)
- Appropriateness of clinical practice patterns
  - Utilization Review: appropriate LOS, denials, avoidable days
- Significant departures from established patterns of clinical practice
- Department specific indicators
- Sentinel event data
- Patient safety data
  - use of “do not use” abbreviations

**CITIZENSHIP**

- Accurate, timely, and legible completion of medical records (quality of H & P’s, notes, etc.)
- Participation in education of patients and families
- Coordination of care, treatment and services with other practitioners and hospital personnel
- Patient satisfaction surveys

May also include:

- Requests for tests and procedures
- Morbidity and mortality data
- Use of consultants
- Other relevant criteria as determined by the medical staff
- Unplanned ACTs
- Wound infections
- Critical events

3. Information resulting from the OPPE is used to determine whether to continue, limit or revoke any existing privileges or initiate a problem specific focused review.

D. The timeframe of data collection must be defined, and the method of collecting data defined.

  - Retrospective review
  - Concurrent review

E. Once the indicators are established and methodology developed for collection of the data, then the task of analysis must occur.

  - Data analysis: Conversion of all raw numbers to rate-based performance.
  - Incumbent on having good denominator data (sufficient numbers)

F. Once the rate-based data is collected on an individual basis, it must be compared to “peer” or departmental performance utilizing industry-accepted standards as in Care Science/Premier or similar data bases/software programs.

G. If no activity during the review period(s), OPPE from hospital(s) where the practitioner has had previous activity will be used at the time of reappointment.

**VI. EXTERNAL REVIEW:**

Circumstances under which monitoring by an external source are required:
1. The MEC or pertinent subcommittee cannot make a determination and requests external review.
2. The individual whose performance is under review requests external review.
3. The Governing Body requests external review.
4. Competition among the service or department members.
5. Lack of sufficient expertise to review.

VII. PEER REVIEW

A. Definition of “Peer”
   1. A peer is defined as a member, in good standing, of the medical staff who is licensed in the same medical specialty and granted clinical privileges in concert with the individual under review. As described in this policy, the “medical staff” includes allied health professionals within the prerogatives outlined in the Medical Staff Bylaws and Rules/Regulations.
   2. Opinions from other peers, not in the same specialty as the individual under review may be offered and considered, regarding specific issues related to the management of the case under review.

B. Peer Review Participants
   1. A peer reviewer is expected to have knowledge of expected standards of practice within the given specialty and have a working knowledge of the peer review process.
   2. Peer reviewers will be assigned as:
      a. A peer assigned by the clinical chief of service to which the individual under review is assigned.
      b. Members of a reviewing committee, including the MEC, assigned by the Chair of the committee.
      c. Members of an ad hoc committee as assigned by the Chair of the Ad Hoc Committee.
      d. A peer requested by the Medical Staff President and/or hospital Administrator.
   3. An individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants that were involved in the patient’s care.

C. SELECTION OF PEER REVIEW PANELS FOR SPECIFIC CIRCUMSTANCES
   1. Peer review panels may be selected in certain circumstances when additional consideration is necessary to adequately review a specific case. “Specific cases” can be defined, but not limited to, cases requiring external peer review, cases resulting from a sentinel event, cases involving intensive assessment and/or investigation of an individual’s clinical competence or professional conduct.
   2. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty upon request of:
      a. A reviewing committee as assigned by the Chair of the committee.
      b. The MEC as assigned by the Chief of the medical staff
      c. An ad hoc committee as assigned by the chair of a reviewing committee or by the MEC as assigned by the Chief of the medical staff.
      d. The Chief of the medical staff and/or facility Administrator.

D. PEER REVIEW ACTIVITIES
   When the results of a monitoring or assessment process or when an adverse event is related to an individual’s performance, or when the professional conduct of an individual is deemed unprofessional, the occurrence will be forwarded to the MEC for determination of the appropriate committee to review the occurrence. Monitoring and assessment of allied health professionals will be forwarded to the Director of Quality Improvement.

Unless the occurrence requires immediate intervention, cases or events referred for peer review are to be reviewed within one (1) month of referral. This includes cases that are reviewed concurrently and retrospectively as part of the ongoing medical record review process.
All cases or events undergoing peer review will have a written summary completed that lists the rationale for the conclusions made by the peer reviewer(s). Once the case has been reviewed, the event is assigned a classification level:

CLASSIFICATION 1 – performance meets Medical Staff expectations of quality. Expected outcome. Treatment appropriate.
CLASSIFICATION 2 – performance meets Medical Staff expectations of quality. Unexpected outcome.
CLASSIFICATION 3 – opportunity for improvement exists. Delay in diagnosis and/or treatment in appropriate.
CLASSIFICATION 4 – episode of care unacceptable. Treatment inadequate.

At the discretion of the committee conducting peer review, follow-up actions may be required, but not limited to:

COMMITTEE ACTIONS:
1. Letter to the individual identifying a need for improvement – no response necessary.
2. Letter to the individual identifying a need for improvement – response/attendance necessary.
3. Letter to the individual requesting additional information.
4. Trending or intensive monitoring of individual’s performance/conduct over a given time period.
5. Recommendation for disciplinary action as outlined in the medical staff bylaws.

E. PARTICIPATION IN PEER REVIEW PROCESSES BY INDIVIDUAL UNDER REVIEW
When an individual’s performance or conduct is scheduled for discussion at a regularly scheduled meeting, the member may be requested to attend. The individual shall be notified at least two (2) weeks prior to the scheduled committee meeting date of the committee’s request for the individual’s presence at the meeting. If a suspected deviation from the standard clinical practice is involved, the notice shall also include: 1) the medical record number; 2) date of admission; and, 3) reason for review. Unless excused for good cause, it is the responsibility of the individual to attend the meeting. Failure to attend when so requested may be grounds for corrective action.

If the individual’s attendance is not warranted, however, the committee requests additional information from the individual regarding management of the case or to provide input regarding the event involving the individual’s conduct, the individual shall be notified within two weeks prior to the scheduled committee meeting date or within five (5) business days following the committee’s regularly scheduled meeting. If the occurrence involves a suspected variance in practice, the notice shall also include: 1) the medical record number; 2) date of admission; 3) reason for review; and 4) the committee’s request for a response. If the occurrence involves professional conduct, the notice shall include: 1) the date of the event; 2) the circumstances for review; and 3) the committee’s request for response.

The individual shall have thirty (30) days in which to respond to the committee’s request in writing. If the individual prefers to attend the next regularly scheduled meeting of the committee, the individual shall notify the chair of the reviewing committee within the same thirty (30) day period. Failure without good cause to respond to a reviewing committee’s request for additional information may be grounds for corrective action.

If the individual’s attendance or input is not requested, the individual whose case or conduct is under review has the right to present his/her information regarding case management or conduct to the committee performing peer review. The individual whose case or conduct is under review has the right to sit on the committee during the time the case or event is reviewed and discussed, to provide additional information to the individuals performing peer review as necessary.
F. PEER REVIEW PROGRAM METHODOLOGY
To provide for an effective functioning and consistent peer review process, the following program methodology will be conducted:

Consistency. All cases referred for peer review shall follow the peer review program components listed above.

Timeliness. Time frames are adhered to in a reasonable fashion. All cases or events referred for peer review shall be reviewed within the time frames listed above. In those instances where peer review falls out of the required time frames, the reasons for the delay will be documented in the medical staff minutes of the committee conducting peer review. All efforts will be made to complete the peer review process as soon as possible.

Conclusions are defensible. All cases or events undergoing peer review will have a written summary completed as outlined above under the Peer Review Activities.

REVIEW ACTIVITIES section. The written summary lists the rationale for the conclusions made by the peer reviewer(s). Rationale must be based on the reason the case was reviewed, and supported by current clinical practice, practice guidelines and/or literature.

Balance. All opinions regarding medical management, including minority opinions, will be considered in the ultimate determination of the case or event. This includes information and opinions from the individual whose case is under review.

Useful. The results of peer review are utilized in the appraisal process at the time of medical staff reappointment and as an ongoing component of the medical staff performance improvement program to improve individual performance. Results of peer review are also utilized in organization-wide performance improvement programs, when appropriate, to improve the organization’s performance and outcome of care.

Ongoing. The peer review program is an ongoing process designed to continuously assess, measure and evaluate the performance of individuals with clinical privileges. Results of peer review are tracked over time to monitor the effectiveness of care provided by the individual, the medical staff as a whole and, when appropriate, by the organization.