MEDICAL STAFF BYLAWS

APPENDIX "D"

MEDICAL STAFF POLICY
REGARDING PEER REVIEW, ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) & FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

This Policy is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the policy and procedures described herein.

SCOPE

Applies to all credentialed members of the Medical Staff and Allied Health Practitioners.

EXCEPTION:
No volume providers with medical staff membership and without clinical privileges per Joint Commission clarification are exempt from the Ongoing Professional Performance Evaluation and Focused Professional Practice Evaluation requirements contained within this document.

I. 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 competence, practice, and the quality and safety of patient care;

To define those circumstances in which an external review or focused review may be necessary;

To address identified issues in an effective and consistent manner.

"Professional Practice Evaluation" is considered an element of the peer review process and the records and proceedings relating to this policy are confidential and privileged to the fullest extent permitted by applicable law.

II. DEFINITIONS

Peer:

For purposes of this policy, the term "Peer" refers to any practitioner who possesses the same or similar knowledge and training in a medical specialty as the practitioner whose care is the subject of review.

Individual Case Review:

The process outlined for peer review of a particular case identified with a potential quality of care issue.

Ongoing Professional Practice Evaluation:

The ongoing process of data collection for the purpose of assessing a practitioner's clinical competence and professional behavior. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the threeyear membership and privilege renewal cycle.

Focused Professional Practice Evaluation:

The time-limited evaluation of practitioner competence in performing a specific privilege or privileges. The process is consistently implemented as a means to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality care.

FPPE affects only the privileges for which a relevant concern has been raised and related privileges for which the same concern would apply. Other existing privileges in good standing should not be affected by the decision to initiate FPPE.

Peer Review

Peer Review is the process by which a practitioner, or committee of practitioners, examines the work of a peer and determines whether the practitioner under review has met accepted standards of care in rendering medical services. The professional or personal conduct of a physician or other healthcare professional may also be investigated. Individual Case Review, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation are components of peer review.

Practitioner Proctoring:

The personal presence of an assigned practitioner who does not have a treatment relationship with the patient, who is designated to provide clinical teaching or to monitor the clinical performance of another practitioner to facilitate quality of care to patients, as required for purposes of credentialing, reappointment, quality improvement, FPPE, or corrective action.

Focused Professional Practice Evaluation (FPPE)

A. Initiation of FPPE

FPPE will be initiated in the following instances:

- Upon initial appointment;
- When a new privilege is requested by an existing practitioner;
- 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. For example, when a trigger is exceeded and preliminary review indicates a need for further evaluation.

A recommendation of FPPE may be made by:

- The Credentials Committee;
- A Department of the Medical Staff;
- The Chief of the Department;

- The Chief of Staff;
- A special committee of the medical staff;
- The MEC

The appropriate department or committee must authorize the initiation of the FPPE, record the date and reason for initiation of FPPE, and designate that the Quality Management Department (or other appropriate designee) shall be responsible for coordinating the FPPE process and reporting back to the department/committee.

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 corrective action as defined in the Medical Staff Bylaws and is not subject to the Bylaws provisions related to the corrective action process. If the outcome of FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.

B. Timeframe for Collection and Reporting

The period of FPPE must be time-limited. Time-limited may be defined by:

- A specific period of time; or
- A specific volume (number of procedures/admissions/encounters)

The duration of FPPE may be tiered for different levels of documented training and experience:

1. Practitioners coming directly from an outside residency program (unknown data)
2. Practitioners coming directly from the organization's residency program (have data)
3. Practitioners coming with a documented record of performance of the privilege and its associated outcomes versus those with no record.

FPPE shall begin with the applicant's first admission(s), encounter(s), or performance of the newly requested privilege. 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 medical staff but may not extend beyond the first biennial reappointment.

C. Methods for Conducting FPPE/Communication to the Practitioner

FPPE may be accomplished by:

1. Chart reviews, both concurrent and/or retrospective
2. Simulation
3. Discussion with the involved practitioner and/or other individuals involved in the care of the practitioner's patients, for example, consulting physicians, surgical assistants, nursing staff or administrative personnel
4. Direct observation/proctoring
5. For dependent AHPs, FPPE methods may include review or proctoring by the sponsoring physician
6. Internal or external peer review

FPPE completed via medical record review may have a screening portion delegated to quality management staff in accordance with their scope of practice. A peer (as defined in Section 11 Definitions) is responsible for judgments regarding the appropriateness of clinical care and determinations of the current competence.

The terms of all FPPE shall be communicated in writing to the affected practitioner or AHP, including the following:

- The cause for the focused monitoring
- The anticipated duration
- The specific mechanism by which monitoring will occur (i.e. chart reviews, proctoring, peer observation, etc.)

D. Conclusion of FPPE

At the conclusion of the initial FPPE, findings will be reviewed by the Medical Executive Committee or responsible Department, for decision and recommendation. Decisions 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 the Medical Staff Bylaws Appendix A (Fair Hearing Plan) will apply.

Each practitioner or AHP will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member or AHP including, but not limited to, the following:

- An overall summary of the findings and outcome of FPPE
- Specific actions, if any, that need to be taken by the practitioner or AHP to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed
- If the focused review is complete or will continue (duration will be specific if the focused review will continue)
- The period of initial FPPE is completed and the practitioner or AHP will move into OPPE
- The period of FPPE for a specific privilege is completed and the practitioner or AHP will continue with OPPE

At the end of the period of focused evaluation, in the event that the practitioner or AHP's activity/volume has not been sufficient to meet the requirements of FPPE:

- The practitioner or AHP may voluntarily resign the relevant privilege(s), or
- The practitioner or AHP may submit a written request for an extension of the period of focused evaluation, or
- If the practitioner or AHP has sufficient volume of the privileges in question at another local facility, external peer references specific to the privilege/procedure may be obtained.
- FPPE may be extended at the discretion of the responsible medical staff department or committee and approved by the MEC and Board.

The practitioner or AHP is not entitled to a hearing or other procedural rights for any privilege

that is voluntarily relinquished. Note that even in the absence of entitlement to hearing rights, a report to the National Practitioner Data Bank may still be triggered.

FPPE practitioner-specific data reports are maintained in the Practitioner or AHP's Confidential Quality File. A summary document/report shall be maintained in the Credentials File. For purposes of this provision, the summary document/report shall mean the general communication letter that was sent to the practitioner following the review informing him/her whether he/she successfully met the established expectation for FPPE during the review period. The summary document/report shall not include quality screens, reviews, data reports, etc., which shall all be maintained in the confidential quality file.

E. Performance Improvement Plan

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff department, committee or chair. The written improvement plan and supporting FPPE outcomes are presented to the Medical Executive Committee for approval. The involved Practitioner or AHP should also be offered the opportunity to address the MEC and respond to the findings before the improvement plan is finalized and implemented.

Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

- Necessary education
- Proctoring and/or mentoring
- Counseling
- Practitioner Assistance Program
- Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or Chief of Staff will meet with the Practitioner or AHP to communicate the improvement plan. If the Practitioner or AHP agrees with the plan, the written document should be signed by the Practitioner or AHP and forwarded to the Quality Department. If the Practitioner or AHP does not agree with the plan and/or refuses to implement the improvement plan, the outcome will be reported to the responsible department chief and/or Medical Executive Committee for resolution.

ONGOING PROFESSIONAL PRACTICE EVALUATION

A. Timeframe for Collection and Reporting

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/or action as specified in this Policy.

B. Indicators for Review

1. The type of data to be collected and related thresholds or triggers is determined by individual medical staff committees/departments and approved by the MEC. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/outlier

trending data. Good performance data should also be considered. The indicators for each specialty / practitioner must be inclusive of the scope of practice / privileges granted for that specialty / practitioner and include the items in Section A below if appropriate to their practice.

a. The organized medical staff measures and assesses processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process:

    i. Use of medications
    ii. Use of blood and blood components
    iii. Operative and other procedure(s)
    iv. Use of anesthesia / sedation
    v. Performance of histories and physicals

b. The Medical Staff may consider the six areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME). These include:

    i. Patient care
    ii. Medical/clinical knowledge
    iii. Practice-based learning and improvement
    iv. Interpersonal and communication skills
    v. Professionalism
    vi. Systems-based practice

c. Information used in the ongoing professional practice evaluation may be acquired through:
    - Periodic chart review;
    - Direct observation
    - Monitoring of diagnostic and treatment techniques
    - Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel.

2. Thresholds/triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable levels of performance within the established defined criteria and are used to identify those performance outcomes that could trigger FPPE. Triggers to consider include, but are not limited to:

Defined number of events occurring
Defined number of individual peer reviews with adverse determinations
Elevated infection, mortality, and/or complication rates
Sentinel events

Increasing lengths of stay in comparison to peers
Increasing number of returns to surgery
Frequent unanticipated readmission for the same issue
Patterns of unnecessary diagnostic testing/treatments
Failure to follow approved clinical practice guidelines

C. Oversight and Reporting

The organized Medical Staff delegates the collection of the selected performance indicators to the appropriate hospital department. The overall process, data compilation and reporting is coordinated by the Quality Management Department.

The review of performance data and any recommendation(s) for action, if necessary, is performed through the medical staff committee process.

D. Results and Reporting of Data Analysis

Data are analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized practitioner or AHP report are referenced in the MEC meeting minutes, maintained in the quality file and incorporated into the two-year reappointment process.

During the course of OPPE, FPPE may be triggered by the following special circumstances:

- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Behavior that undermines a culture of safety

Practitioners will be notified in writing when any trigger results in resumption of FPPE. The appropriate department or committee must authorize the initiation of the FPPE, record the date and reason for initiation of FPPE, and designate that the Quality Management Department (or other appropriate designee) shall be responsible for coordinating the FPPE process and reporting back to the department/committee.

If unprofessional behavior or disruptive conduct is identified as a possible concern, the Behavior that Undermines a Culture of Safety Policy (Appendix C) will be initiated as a component of the OPPE.

RESPONSIBILITIES OF THE QUALITY MANAGEMENT DEPARTMENT:

1. The Quality Management Department will be responsible for compiling and reporting results of FPPE and OPPE to the Medical Staff Committee(s).

2. A OPPE practitioner or AHP-specific profile that illustrates performance over the two-year reappointment cycle will be utilized at the time of reappointment.

3. The Quality Management Department will be responsible for collaborating with each Medical Staff Committee/Department on an annual basis to review the continued relevance of the selected indicators and triggers.

4. The Quality Management Department must obtain authorization from the appropriate department or committee prior to initiating a specific FPPE or individual case review process.

Individual Case Review Process

Cases identified with potential quality of care issues are referred to the appropriate Medical Staff Department or Committee for review. The appropriate Department or Committee authorize the initiation of the review, record the date and reason for initiation of the review, and designate that the Quality Management Department (or other appropriate designee) shall be responsible for coordinating the review process and reporting back to the Department/Committee.
Cases may be identified through OPPE, FPPE, case management, risk management, audits, sentinel events/serious safety events, clinician referrals, and other sources. All cases are initially screened by the Quality Management department utilizing medical staff approved screening criteria, prior to forwarding for medical staff review. If the medical staff reviewer determines there are no potential quality of care issues identified the case is closed, the findings are documented and trending is performed in the Quality Department.

If potential quality of care issues are identified by the medical staff reviewer the following process for peer review shall be implemented:

A. Reviewer Selection & Duties

Reviews are completed by a member of the MEC

Note:
A designated reviewer may not review a case where he/she participated in the care, or if there is a conflict with the medical staff member involved as determined by the MEC and/or Board in their sole discretion

B. Reviewer Disqualification & Replacement

If a reviewer does not feel he/she can adequately review a medical record due to a conflict of interest or believes he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee, Department Chief or Chief of Staff. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer.

C. Communication to Involved Practitioner

Any Practitioner or AHP who is the subject of a review receiving an assigned peer review score of 3 or greater, shall be notified in writing at least two weeks prior to the medical staff meeting where the outcome of review is reported. Communication shall include the case medical record number, admission/discharge date, reason and outcome of the review. Comments and/or opinions made by the reviewer may be included, however, the identity of the reviewer should be redacted.

The involved Practitioner or AHP is provided the opportunity to respond to the results of the review in writing in advance of the meeting where the outcome is reported. At the request of the Department Chief, or Chief of Staff, the Practitioner or AHP may be invited to attend the meeting and discuss the case.

D. Circumstances Requiring External Peer Review

The MEC, Chief of Staff, Department/Chair, Peer Review Committee/Chair or the Board of Trustees may request external peer review by a practitioner who is Board certified within the same specialty in circumstances, including, but not limited to, the following:

- The pool of eligible reviewers is unable to serve
- There is no qualified practitioner on staff to conduct the review
- Litigation risk
- The facility has only a single practitioner in a particular specialty and no other practitioner has similar background, training or experience
- The procedure is new to the organization
- Other reasons as deemed by the MEC and Board.

No practitioner or AHP may require the Hospital to obtain external peer review if it is not deemed necessary by the Chief of Staff, MEC, Department Chair, Peer Review Committee or the Board of Trustees.

E. Review Form Summary

Reviewing practitioners must complete the Peer Review Form, Attachment One, clearly and concisely. The reviewing practitioner must sign his/her name on the review form and shall grade the care and outcome based on the following schedule:

1 = Most experienced, competent practitioners would have handled the case in a similar manner.
2 = Most experienced, competent practitioners might have managed the case differently.
3= Most experienced, competent practitioners would have managed the case differently.

DOCUMENTATION OF PEER REVIEW ACTIVITIES:

Reports of OPPE, FPPE and individual case review findings and recommendations shall be presented to the MEC. The MEC may adopt the recommendations of the Medical Staff Department/Committee and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.

All recommendations of the MEC other than for further investigation shall be delivered to the Board. The Board shall make a final determination concerning any actions warranted based on the findings and recommendations of the MEC.

Results of OPPE, FPPE and Peer Review outcomes shall be documented and maintained in the practitioner's quality file and referenced at reappointment.

A summary of OPPE shall be provided to the MEC and Board ; e.g every six (6) months to every nine (9) months

FPPE reports will be provided to the MEC and Board at every meeting.

A summary of Peer Review outcomes shall be reported to the Board on at least a quarterly basis.

Practitioner Review of Confidential Quality File

A practitioner or AHP may review his quality file by making an appointment with the Director of Quality Management / Chief Quality Officer. The Chief of Staff will be notified. No copies of the quality file may be made, nor may the practitioner or AHP remove any portion of the quality file from the Hospital. In the discretion of the CAO, in consultation with the Chief of Staff, personal information, such as the identity of external or internal peer reviewers, or the identity of patients or employees reporting quality issues, may be redacted before the practitioner or AHP may review the file.