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| **Figure 5.1** | **Professional Evaluation Policy** |
| SUBJECT: Professional Evaluation Policy SECTION/DEPT: Medical Staff Services POLICY #: REFERENCE: REVISIONS:  APPROVED BY:  Medical executive committee: DATE: Governing board: DATE: CEO: DATE:  Medical staff president: DATE: Governing board chair: DATE:   1. **PURPOSE**    1. To establish an objective, systematic process by which to evaluate the competence of practitioners who do not have documented evidence of performing the requested privilege(s) at [Hospital name] and to ensure sufficient evidence-based clinical data to assess ongoing professional practice and com- petence. Throughout this policy, the phrases “ongoing and focused professional practice evaluation” (OPPE and FPPE) replace the traditional phrase “peer review.” 2. **DEFINITIONS**    1. FPPE is a process during which the practitioner’s professional performance is evaluated to confirm current competence. The process is privilege-specific, evidence-based, and time-limited.    2. OPPE is a process by which ongoing, specialty-specific clinical data are obtained for all credentialed, privileged practitioners.    3. Proctoring is direct evaluation in real time to observe performance in an actual situation.    4. Indicators or practitioner performance measures show how a practitioner is performing and include case review, rules, and rates. | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. Six core competencies of patient care:    1. Patient care: Availability and thoroughness in providing compassionate patient care, respon- siveness, and accessibility    2. Medical/clinical knowledge: Knowledge of established and evolving biomedical, clinical, and social sciences; technical and clinical skills; clinical judgment; and use of consultants when indicated    3. Practice-based learning and improvement: Use of scientific evidence and methods in patient care practices    4. Interpersonal and communication skills: Medical record timeliness, clarity, and completeness; verbal and written fluency in English; good physician/patient relations; and ability to work and communicate effectively with others    5. Professionalism: Ethical conduct, sense of responsibility, relationships with hospital staff, and participation in medical staff functions    6. Systems-based practice: Understands context and systems in which healthcare is provided and sharing of limited resources 2. **GOALS**    1. To identify opportunities for practice and performance improvement and to recommend action as needed for individual credentialed practitioners    2. To monitor significant trends in performance by analyzing aggregate data and case review findings    3. To ensure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful 3. **POLICY**   It is the policy of [Hospital name] to perform OPPE and FPPE and to evaluate findings about individual prac- tice and performance.   1. **SCOPE**    1. This policy applies to all credentialed medical and allied health staff who have clinical privileges.    2. Data are considered during decisions to maintain, revise, or revoke existing clinical privileges. | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. **PROGRAM ELEMENTS**    1. Evaluation of an individual practitioner’s professional performance    2. Opportunities to improve care based on recognized standards    3. The six areas of general competencies    4. Multiple sources of information, such as individual case review findings; compliance with hospital pol- icies and rules; compliance with medical staff bylaws, rules, and policies; and the use of rates com- pared to established benchmarks or standards    5. Feedback to individual practitioners 2. **PROCEDURE**    1. Indicator selection and review       1. Each clinical service line will establish measures for its members and determine thresholds for acceptable and excellent performance for specialty and service-specific indicators.       2. The quality department will work with each clinical service to periodically review the continued relevance of the indicators chosen and assist with updating the indicators as directed by   the service.   * + 1. The medical staff quality committee (MSQC) will approve and periodically review service line, specialty, and hospitalwide indicators.   1. Report preparation, distribution, and review      1. The quality department will prepare and distribute quality reports to individual practitioners and their clinical service chairs at least every eight months.      2. The clinical service line chair’s report will be sent to the vice chair or recent past chair of that service.      3. Each clinical service chief is responsible for reviewing service line reports, signing the report, and returning it to the quality department within 30 days.      4. Quality reports will be kept in each practitioner’s peer review file.      5. Chiefs who do not complete review as noted above will be contacted by the MSQC chair or designee. | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. Use of data for credentialing    1. The MSQC will provide the credentials committee with evidence-based, clinical activity infor- mation that is systematically collected through the quality process for privileged practitioners.    2. The medical staff services department will maintain physician peer review files that include quality reports.    3. The medical staff services department will assist clinical service chiefs in reviewing quality reports at the time of reappointment.    4. Additional information will be obtained from documentation of participation in continuing education, preceptor, and teaching assignments; wellness committee and risk management reports; and patient and staff feedback.    5. Clinical performance information for credentialed allied health professionals who do not have data in the quality system will be obtained by ongoing case review by the supervising physi- cian(s). At least five cases per year must be reviewed and the results forwarded to the quality department. 2. Consequences of poor performance    1. Practitioners who are found to be at or lower than the hospital’s or service’s established threshold for performance may be required to develop a plan for improvement in conjunction with the clinical service chair, MSQC, and credentials committee.    2. If the medical/professional staff member continues to perform below threshold expectations, an FPPE plan may be required. 3. FPPE    1. FPPE is used for an initial assessment of proficiency for all newly requested privileges:       1. At the time of initial granting of privileges to all new practitioners       2. When a current practitioner requests additional new privileges (prior to privileges being independently granted)    2. FPPE is also initiated when a question arises regarding a practitioner’s ability to safely provide quality patient care, such as:       1. Before eturn to practice after a leave of absence       2. When potential health concerns exist       3. When a physician is resuming privileges voluntarily placed in abeyance       4. When there is a significant variation from accepted standards of clinical performance       5. When there is an unexpected or unfavorable patient outcome | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. When there are findings from sentinel or significant event 2. When there are identified trends 3. FPPE may be initiated when ethical concerns arise, such as:    1. Conflicts of interest    2. Disclosure to patients    3. Consent issues 4. FPPE may be performed using a variety of methods, including the following:    1. Prospective case review    2. Concurrent case review (proctoring or direct observation)    3. Retrospective chart review    4. Monitoring    5. Simulation    6. External peer review    7. Discussion with other caregivers 5. Plan development (clinical service line chief):    1. Assists the credentials committee in developing an FPPE plan and identifying potential monitors    2. Intervenes and adjudicates any conflict between the monitor and the practitioner    3. Refers a case for peer review if indicated    4. Recommends to the credentials committee that additional or revised monitoring requirements be imposed    5. Recommends to the credentials committee that corrective action be taken at any time during the monitoring period 6. **PLAN DEVELOPMENT (CREDENTIALS COMMITTEE)**    1. Recommends the minimum number of cases/procedures to be monitored and/or proctored    2. Recommends whether and when the monitor must be present during procedures | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. Recommends the method and duration of monitoring, which may be altered if initial concerns are raised that indicate that further evaluation is required or if there is insufficient activity during the initial period 2. Recommends potential monitors 3. Determines whether evidence of monitoring from a healthcare facility other than [Hospital name] may be used to supplement in-house monitoring if the following criteria are met:    1. The practitioner being monitored must have privileges at the facility providing the data    2. The monitor at the other facility must be qualified and credentialed to perform the procedure being monitored    3. The practitioner being monitored must consent to authorize the other facility to release copies of the proctoring reports or to provide a summary of proctoring activities 4. Considers the practitioner’s previous experience in developing the FPPE plan 5. Selects an outside monitor if a conflict of interest has been declared 6. **FPPE FOR PERFORMANCE ISSUES**   Performance issues that trigger focused review may include the following:   * 1. Low-volume procedures   2. A sentinel event   3. A complaint   4. A variance from acceptable practice patterns or comparative peer performance data   5. Return to practice after significant time lapse   6. Potential health concerns  1. **MEASURES TO ADDRESS PERFORMANCE ISSUES**    1. On recognition of a significant rate of complication, a sentinel event or outcome, or a deviation from practice or standards, the medical executive committee may call for a focused professional practice review of a specific practitioner. The review shall be for a specified period of time, not to exceed three months. The findings will be evaluated by the medical executive committee and a determination made to extend the evaluation, cease the intense monitoring, or recommend actions to the board. The crite- ria will be specific to the issue or concern and may include but is not limited to medical record review, assigning a proctor, limiting scheduled procedures, ongoing record review, and recommendations from peers, staff, and others. | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. The medical executive committee will meet with the practitioner to discuss issues and obtain feedback. 2. External review will be performed based on requirements outlined in the [Policy]. 3. **MONITORING**    1. The medical staff services department informs the appropriate hospital departments about practitioners being monitored and maintains contact with the practitioner and the monitor to ensure that monitoring is being conducted as required.    2. The practitioner being monitored coordinates with the monitor in advance of a scheduled procedure if the case is being directly observed, provides the monitor information on a specific case as requested, and informs the patient of the right to refuse a procedure being performed as part of a monitoring or proctoring program.    3. The practitioner serving as monitor completes the approved practitioner competency evaluation form or provides a comparable narrative description of FPPE and promptly notifies the clinical service chief if, at any time during the monitoring period, the monitor has concerns about the practitioner’s compe- tence to perform specific clinical privileges or care related to a specific patient. 4. **REPORTING**    1. At the end of the monitoring period, the clinical service chief will report to the credentials committee concerning the monitored practitioner’s qualifications, competence, and conduct regarding these clinical privileges and whether a sufficient number of cases has been reviewed to properly evaluate the practitioner’s competence regarding the clinical privileges requested.    2. The credentials committee will make a recommendation to the medical executive committee, including measures to be taken to resolve any performance issues identified.    3. Medical executive committee will make a recommendation to the governing board.    4. If, as a result of information obtained during monitoring, the credentials committee recommends ter- mination of the physician’s appointment or additional privileges due to questions about qualifications, fitness, professional behavior, or clinical competence, the physician shall be entitled to the fair hearing procedures as outlined in the medical staff bylaws. | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. **RECOMMENDATIONS**    1. If at any time during the provisional period the clinical service chief to which the practitioner has been assigned determines that the practitioner is not competent to perform the specific clinical privileges and that the continued exercise of those privileges may jeopardize patient safety, the clinical service chief shall report these findings to the credentials committee.    2. The credentials committee shall review the evaluators’ reports and relevant medical records and make a recommendation regarding continued appointment and clinical privileges.    3. The credentials committee shall forward its recommendations to the medical executive committee.    4. If necessary, the medical executive committee may impose a precautionary suspension as outlined in the medical staff bylaws.    5. The medical executive committee shall forward its recommendation to the board.    6. Proctoring       1. The proctor’s role is that of an evaluator of technical and cognitive skills. The proctor is not a teacher, consultant, or mentor.       2. The proctor does not have a formal physician/patient relationship with the patient being proctored.       3. The proctor must be present during the procedure/care being provided and will render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.       4. Any such intervention must be immediately reported to the appropriate clinical service chief.       5. A practitioner serving solely as a proctor for the purpose of assessing and reporting on the competence of another practitioner is an agent of the hospital.       6. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from acts or omissions in the role of proctor except acts or omissions that constitute gross negligence or willful misconduct.       7. The proctor shall receive no compensation from any patient for this service. Billing must be consistent with Medicare guidelines.       8. If no other physician is qualified or credentialed to serve as proctor or if a conflict of interest prevents local practitioners from serving as proctors, an outside proctor may be retained. | |

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| **Figure 5.1** | **Professional Evaluation Policy (cont.)** |
| 1. Any outside proctor or monitor must be approved by the credentials committee.    1. It is the responsibility of the provisional physician to notify the assigned proctor and the OR scheduler in advance of a scheduled procedure and to make arrangements with the proctor for direct observation of all procedures as required by the department    2. To assist in tracking cases that have been proctored, it is recommended that the provisional staff member maintain a record of all proctored procedures    3. If a practitioner fails to complete proctoring requirements within the specified time frame, the practitioner shall be notified in writing and given an opportunity to request a meeting with the credentials committee       1. At that meeting, the practitioner may present evidence of extenuating circumstances and why the evaluation period should be extended.       2. The credentials committee will make a written report and recommendation to the medical executive committee.       3. The medical executive committee may either adopt the credentials committee’s recom- mendation, refer the matter back to the credentials committee with specific concerns or questions, or recommend differently than the credentials committee to the governing board. The decision of the board shall be final.       4. If privileges are relinquished or if termination of medical staff membership and/or priv- ileges is recommended, the medical staff bylaws on fair hearing procedures shall be followed. | |