Major Hospital A Major Health Partner	Medical Staff Professional Practice Evaluation MS-19
Does this policy meet a regulatory requirement? _X_ Yes __No	Formulated by: Medical Office Staff Approved by: Medical Executive Staff, Board of Directors Effective Date: 01/01/2015

PURPOSE: **To ensure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its practitioners, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice, and care. The focused efforts toward improving individual performance complements the ongoing quality improvement activities focused on the improvement of care delivery system.**

Throughout this policy, the phrase "ongoing professional practice evaluation" (OPPE) or "focused professional practice evaluation" (FPPE) serves to replace the traditional phrase "peer review." Refer to the Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Statute IC 34-30-15-1 et seq. This policy refers to the records and proceedings of the quality review of the medical staff.

GOALS: **Identify opportunities for practice and performance improvement of individual practitioners and take action as needed. Practitioners are members of the medical staff/non-physician practitioners with clinical privileges granted by the Board of Directors of Major Hospital.**

Ensure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful.

GUIDELINE STATEMENTS:

1. **Policy**
   It is a policy of Major Hospital to perform ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE). Ongoing data review and findings about individual practice and performance are evaluated by the Medical Executive Committee.
2. **Ongoing Professional Practice Evaluation:**
   OPPE is a program that allows the medical staff to identify professional practice trends that impact quality of care and patient safety on an ongoing basis.
   2.1. The areas of competence evaluated in OPPEs will include two (2) or more administrative indicators and two (2) or more clinical indicators pertinent to the practitioners' clinical privileges. The Medical Executive Committee in collaboration

with the Medical Staff Office will develop a written report for each OPPE, including, if appropriate, recommendations for action.

2.2. The Medical Executive Committee (MEC) will establish measures for its practitioners, sufficient to assess the members' (medical/non-physician practitioner) competence. Individual data will be collated and reported to the MEC. At least every two (2) years, the Medical Staff will identify and approve performance measurements that are specific to services provided by the practitioners (including medical, non-physician practitioner).

2.3. The OPPE program includes:

2.3.1. The evaluation of an individual practitioner's professional performance and includes opportunities to improve care based on recognized standards.

2.3.2. The use of multiple sources of information including, but not limited to, the review of individual cases, aggregate data, compliance with hospital policy, rules and regulations of the medical staff, bylaws and the use of rates compared against established benchmarks and triggers for additional, focused monitoring. Practitioner-specific ongoing review of performance data during the two-year reappointment period shall be summarized at a minimum of three (3) times. The quality department and appropriate hospital staff will assist the medical staff office in data collection and in the compilation of the report.

2.3.3. This process includes feedback to the individual practitioner on evaluation of care based on recognized standards and the effectiveness of his/her professional, technical, and interpersonal skills in providing patient care at Major Hospital. Practitioner-specific evaluation reports shall be completed three (3) times in a two (2) year period. If a trigger is met, the practitioners' evaluation report will be reviewed by the appropriate Medical Staff Officer/Director or designee who shall forward a report to the MEC with his/her recommendation(s). If the MEC decides the trigger affects the provision of safe, high-quality patient care, focused professional practice evaluation will be implemented.

2.3.4. OPPE information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or revoke existing privilege(s) prior to or at the time of reappointment.

2.3.5. Results of the ongoing professional practice evaluation will be communicated to the practitioner, documented in his/her credentials file and reviewed at time of reappointment.

2.3.5.1. Practitioner will receive notice of OPPE trigger and Service Chief recommendation with each evaluation cycle.

2.3.6. Practitioners who do not admit/utilize the hospital with adequate frequency for assessment or are in a specialty that does not provide inpatient hospital care shall be responsible for providing alternative information for review that will allow an informed decision regarding professional practice evaluation. If OPPE is available from a practitioners' primary facility, it may be utilized and shall be reviewed by the appropriate Medical Staff Officer/Director or designee who shall forward a report to the MEC with his/her recommendation.

3. Focused Professional Practice Evaluation:

FPPE is a time-limited evaluation of practitioner's competence in performing a specific privilege. The Medical Staff Officer/Director or designee will notify the involved practitioner of the focused professional practice evaluation. The FPPE process is designed to be a fair, balanced, and educational approach to ensure the competency of the staff. This process is implemented for:

3.1. All new privileges at initial appointment or additional privileges granted by the Board of Directors.

3.1.1. FPPE peer evaluations by Medical Staff Officer/Director or designee following a three-month period or a specific number of cases (as determined by the MEC).

3.1.2. Data sources for the focused evaluation are defined and may include, but not limited to:

3.1.2.1. Personal interaction with the practitioner by the evaluator

3.1.2.2. Detailed medical record review

3.1.2.3. Monitoring of performance indicators and/or aggregate data

3.1.2.4. Input from colleagues, consultants, nursing personnel, Administration and other hospital staff as appropriate.

3.2. To evaluate the performance of practitioners when issues affecting the provisions of safe, high-quality patient care are identified.

3.2.1. Triggers for review may include but are not limited to:

3.2.1.1. Significant variation from accepted standards of clinical performance

3.2.1.2. Unexpected or unfavorable patient outcome

3.2.1.3. Findings from sentinel or significant event or complaints
3.2.1.4. Identified trends
3.2.1.5. Repeated failure to follow hospital policy or medical staff bylaws
3.2.1.6. Peer review events with an adverse determination
3.2.1.7. Minimal target level of performance has not been met by OPPE

3.2.2. Information for evaluation may be derived from the following:
3.2.2.1. Discussion with individuals involved in the care of patients (consulting physician, assistance in surgery, nursing, etc.)
3.2.2.2. Chart review
3.2.2.3. Monitoring clinical practice patterns
3.2.2.4. Direct Observation
3.2.2.5. Cases may be referred for external peer review when the following occurs:
3.2.2.5.1. There is no member who qualifies as a "peer," or expertise is lacking
3.2.2.5.2. Conflict of interest exists that cannot be appropriately resolved by the MEC or the Board of Directors
3.2.2.5.3. Need for opinion from an impartial, expert outsider due to confusing, ambiguous, or conflicting internal review opinion
3.2.2.5.4. There is potential for medical malpractice suit; corporate legal counsel or risk management may recommend external review
3.2.2.5.5. At the discretion of the MEC (with the exception of the Board of Directors, the MEC has final decision if an external review is required)

3.2.3. If the MEC determines that an improvement plan is required, the plan may include:
3.2.3.1. Additional review
3.2.3.2. Continuing education
3.2.3.3. Counseling
3.2.3.4. Corrective action as defined in the Medical staff Bylaws (NOTE: Any corrective action taken must be within the requirements of the Medical Staff Bylaws and the provisions for Fair Hearing and Appellate Review).

3.2.4. The improvement plan must be documented and include the requirements, who Is accountable, and how the improvement will be measured and documented.

This information must be shared with the practitioner to review findings and submit opinions.

3.3. The Medical Executive Committee leadership is responsible to submit recommendations to the Board of Directors regarding: a) the need to continue the FPPE, and b) continuation or limiting of the privilege.

4. Confidentiality

Access to credentials files is limited to authorized individuals who have a legitimate need for access based upon their responsibilities as a medical staff leader or hospital employee. Access to information will be to the extent necessary to carry out assigned responsibilities and is monitored by the Medical Staff Office. Access to credentials files is limited to the following:

4.1. Members of the Board of Directors
4.2. Medical Executive Committee
4.3. Chief Medical Staff Officer
4.4. Medical Staff Directors
4.5. Personnel working in the Medical Staff Office
4.6. Surveyors for accrediting bodies with appropriate jurisdiction (HFAP or state/federal regulatory bodies)
4.7. Others who may be otherwise authorized

5. Reviewing & Revising

Reviewed	Revised
	05/23/16
	12.11.19
	06.27.22

UPDATE WEBSITE WITH REVISIONS

Reference

HFAP Hospital Manual 2021 03.15.01: Ongoing Professional Practice Evaluation & 03.15.02: Focused Professional Practice Evaluation