Legacy Health

Medical Staff Policy Regarding Peer Review, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE)

MQ&CC Approved 6/16/16

SCOPE: Applies to all credentialed members of the Medical Staff and Allied Health Practitioners who hold privileges. (Practitioners that hold membership and have no clinical privileges are considered exempt from this policy.)

PURPOSE: To assure that each Legacy Health medical staff assesses the ongoing professional practice and competence of its staff by conducting professional practice evaluations and uses the results of these assessments to improve professional competence, practice and the quality of patient care consistently for care that occurs within Legacy Health.

This Policy also is to define those circumstances in which a focused review or an external review may be necessary.

"Professional Practice Evaluation" is considered an element of the peer review process and therefore the documents associated with this policy are consider confidential and privileged under ORS 41.675 & 41.685, RCW 4.24.250 & 70.41.200, the federal Health Care Quality Improvement Act of 1986 and other applicable law.

DEFINITIONS:

Peer: For the 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: Case Review is the review by a peer of the medical management by a physician (or allied health provider) in one case. It is intended to consider questions about medical decision-making, management or technique.

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 practitioner's reappointment. Individual Case Review is a component of OPPE.

Focused Professional Practice Evaluation: The time-limited evaluation of a practitioner's competence in performing a specific privilege or group of privileges. This process is consistently implemented as a means to verify clinical competence for all practitioners initially requesting privileges, for existing practitioners who request a new privilege, FPPE is not considered an investigation or corrective action as

defined in the Medical Staff Bylaws and is not subject to the provisions in the Bylaws related to the investigation procedure.

FPPE-Focused Review: An evaluation of a practitioner's competence whenever a question arises regarding a practitioner's ability to provide safe, quality patient-care. FPPE Focused review may be triggered at any time when questions arise related a practitioner. A Focused Review 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 a FPPE Focused Review.

FPPE is not considered an investigation or corrective action as defined in the Medical Staff Bylaws and is not subject to the provisions in the Bylaws related to the investigation procedure. If a FPPE Focused review results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws will be followed.

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. The professional or personal conduct of a practitioner may also be investigated. Individual Case Review, Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation including Individual Case Review, are components of peer review.

Proctoring: The direct presence of an assigned practitioner who does not have a treatment relationship with the patient, who is designated to provide clinical teaching or is assigned to monitor the clinical performance of another practitioner as required for the purposes of credentialing, privileging, quality improvement activities such as FPPE or through corrective action.

I. Focused Professional Practice Evaluation (FPPE)

A. Initiation of FPPE: FPPE will be initiated in the following instances:

- All new privileged practitioners
- When a new privilege is requested by an existing practitioner
- When a question arises concerning an existing practitioner's professional performance that may affect quality or safety of patient care *(also referred as a Focused Review)*

A recommendation of FPPE may be made by:

- The Credentials Committee
- A Department of the Medical Staff
- The Chair or Physician Advisor of the Department and/or Section
- A special committee of the medical Staff such as the Peer Review Committee or Officers
- The Medical Executive Committee

The FPPE monitoring plan for a new practitioner, or newly requested privilege(s), will be specific to the requested privilege or group of privileges.

B. Timeframe for Collection and Reporting FPPE for new privileges

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

- A specific period of time;
- A specific volume (number of procedures)

The medical staff may take into account the practitioner's current or previous experience in determining approach, extent, and timeframe of FPPE needed to confirm current competence.

FPPE shall optimally be completed within a suitable period based upon volume (typically within the first six months from the practitioner's appointment). 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. If FPPE has not been completed by the date of the first biennial reappointment, the practitioner must re-request for the privilege.

In instances where the practitioner does not have sufficient volume to conduct an FPPE assessment and is deemed necessary to remain on the medical staff, medical staff services will obtain a professional reference that can speak to the privileges in question.

C. Evaluation Methods for Conducting FPPE

FPPE may be accomplished by:

- Chart review
- Clinical practice patterns (including Quality Data Review)
- Simulation
- Prospective proctoring
- Direct observation/proctoring
- Internal or external peer review
- Input from individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing staff, ancillary staff and/or administrative personnel)
- For dependent allied health practitioners, FPPE methods may include review or proctoring by the sponsoring physician.

D. Performance Monitoring Criteria and Triggers for Focused Review

Monitoring criteria, including specific performance elements to be monitored, as well as thresholds or triggers, are developed and approved by the medical staff or medical staff department/committee. The triggers are defined as potentially unacceptable levels of performance. Triggers to consider include but are not limited to:

- Deviations from standards of medical care as defined by the Medical Staff Quality Indicators and/or Performance Indicators
- Deviations from well-established community standards of medical care
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations

E. Notification of a Focused Review

In instances when a question has been raised the medical staff member will be informed that there is an ongoing focused review. The practitioner may be asked to provide a brief written commentary regarding the issues related to this review.

F. Conclusion of FPPE

At the conclusion of the initial FPPE, findings will be reviewed by the Credentials Committee for recommendation. Recommendations 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 forwarded from the Credentials Committee to Medical Executive Committee and Medical Quality & Credentials Committee. For recommendations resulting in restriction, suspension, revocation of privileges or other limitations on privileges, the processes pursuant to the Medical Staff Bylaws will apply.

Each practitioner will be notified of his/her performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff Member that will include the following:

- Findings and outcome of FPPE
- Specific actions, if any, that need to be taken by the Practitioner to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed; and
- If the focused review is complete or will continue
- The period of initial FPPE is completed and the practitioner will move onto OPPE

In the event that the practitioner's activity/volume has not been sufficient to meet the requirements of FPPE:

- The practitioner may voluntarily resign the relevant privilege(s) or;
- If the practitioner has sufficient volume of the privileges in question at another Legacy facility, documentation of this data and completion of FPPE may be considered as part of the evaluation
- FPPE may be extended at the discretion of the responsible medical staff section/department or committee.

The practitioner is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished.

Results of FPPE will be maintained in the Practitioner's Confidential Quality File.

G. Performance Improvement Plan for Focused Reviews

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff section/department, committee or chair. The written improvement plan and supporting FPPE outcomes should be presented to the Credentials Committee and then forwarded to the Medical Executive Committee for approval. The involved Practitioner should also be offered the opportunity to address the committee 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
- Concurrent chart reviews
- Suspension or revocation of privilege(s), subject to the provisions of the Bylaws.

Following approval by the Medical Quality and Credentials Committee (MQ&CC), the Department or Committee Chair, Medical Staff President or designee will communicate the improvement plan to the practitioner in writing and request agreement.

II. Ongoing Professional Practice Evaluation (OPPE)

A. Timeframe for Collection and Reporting

OPPE will be initiated and reported on all practitioners with clinical privileges. Results of OPPE will be reported for review and/or action every six months.

B. Indicators for Review

The type of data to be collected and the related threshold, or triggers, is determined by the individual medical staff committees/department and approved by the Medical Staff. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on a regular basis.

- The Medical Staff will select general indicators that apply to all credentialed practitioners.
- Each medical staff department will select specialty-specific indicators based upon their clinical service. These indicators may be evidence-based, such as post-op infection rate, etc.
- The Medical Staff may also consider using the six areas of "General Competencies" (I would quote from TJC requirements). These include:
    - Patient care
    - Medical/clinical knowledge
    - Practice-based learning and improvement
    - Interpersonal and communication skills
    - Professionalism
    - Systems-based practice

C. Performance Thresholds/ Triggers

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 Focused Review. Examples of triggers may include,

- Defined number of individual peer reviews with adverse determinations
- Elevated infection, mortality, and/or complication rates
- Increased length of stay in comparison to peers
- Number of returns to surgery in comparison to peers
- Frequent unanticipated readmissions for the same issue
- Failure to follow approved clinical practice guidelines

D. Oversight and Reporting

The organized Medical Staff delegates the collection of the selected performance indicators to the Quality and Patient Safety department. This department is responsible for compiling the data and presenting it to the appropriate medical staff leader, department or committee.

E. Results and Reporting of Data

Data are analyzed and reported to determine whether to continue, limit or revoke any existing privilege(s). The results of these reports will be incorporated into the reappointment process.

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

- Deviations from standards of medical care as defined by the Medical Staff Quality Indicators and/or Performance Indicators

- Deviations from well-established community standards of medical care
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations

At the completion of the review period, the practitioner profile report containing the OPPE metrics may be communicated to the individual practitioner.

III. Individual Case Review Process

Cases identified that prompt questions about medical decision-making, management or technique are referred to the appropriate Medical Staff Committee for review. The Quality and Patient Safety Department is responsible for coordinating the Peer Review Process.

Cases may be identified through FPPE, OPPE, case management, risk management, audits, sentinel events, clinician referrals, and other sources.

- Cases are identified for review through selected indicators and by referral.
- Case Review Intake is a centralized processing portal through which cases are accepted for review, routed via Legacy or secure email to the designated reviewers, and the completed review forms are received for record keeping.
- The designated case reviewer performs the review within a designated timeframe and completes and returns the case review form to Case Review Intake. Cases determined to represent an "opportunity for improvement" require some action by the reviewer or Chair and ultimately including communication to the involved provider under review.
- Completed case reviews are routed to the Department Chair for oversight and to be sure any required actions are completed. Cases determined to represent "opportunities for improvement" populate the OPPE profile, again so the Department Chair is in the loop.
- Medical Staff leadership oversees this process, receives a periodic report of the reviews completed and findings, and considers the case reviews as a part of the credentialing process. The following process for peer review shall be implemented:

A. Reviewer Selection & Duties

Reviews are completed by the designated Medical Staff Practitioner, Department or Committee (based upon the particular medical staff structure).

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 believe he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee, Department Chair , Physician Advisor or Medical Staff President. If the chair concurs, the chair shall reassign the record(s) to another reviewer. Should the hospital have only one practitioner in a particular specialty, or the pool of eligible reviews is otherwise conflicted or unable to serve, the committee or the Medical Staff President may request an external peer review by a practitioner who is Board certified within the same specialty.

C. Communication to Involved Practitioner

Cases determined to represent an “opportunity for improvement” require some action by the reviewer or Chair and ultimately including communication to the involved provider under review.

- Completed case reviews are routed to the Department Chair for oversight and to be sure any required actions are completed. Cases determined to represent “opportunities for improvement” populate the OPPE profile, again so the Department Chair is in the loop.

D. Circumstances Requiring External Peer Review

If no practitioner on staff is qualified to conduct a review, the appropriate committee, MEC, Medical Staff President, Department Chair, Physician Advisor or the Medical Quality & Credentials Committee may request and external peer review by a practitioner who is Board certified within the same specialty. External Peer review may be necessary, but not limited to the following circumstances:

- The pool of eligible reviewers are unable to serve
- There is no qualified practitioner on staff to conduct the review
- Litigation risk
- The facility only has a single practitioner in a specific specialty and no other practitioner has similar background, training or experience.

No practitioner may require the Medical Staff or Hospital to obtain an external peer review if it is not deemed necessary by the Medical Staff President, Medical Executive Committee or Medical Quality and Credentials Committee.

IV. Sharing of PPE Information within the Legacy Health System

Information related to FPPE or OPPE may be shared among the medical staffs associated within Legacy Health in accordance with the Legacy Health Authorization for Release of Credentialing and Peer Review Information document. This Information will be considered as a supplement for assessing competency.

Each medical staff, is responsible for reviewing the information received and is responsible for making its own evaluation whether the practitioner is competent to perform a procedure or if further documentation or review is needed.