Banner Health

POLICY and PROCEDURE

TITLE: Medical Staff Focused Professional Practice Evaluation Policy			
Number: 13606		**Version: 13606.1**	
Type: Administrative		**Author: Sandy Severson**	
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Facility: System			
Population (Define): All Employees			
Replaces:			
Approved by: Peer Review Council, Administrative Policy Committee, Senior Management Team			

TITLE: *Medical Focused Professional Practice Evaluation*

I. Purpose/Expected Outcome:

A. To define a process to evaluate performance of all providers when 1) new privileges are requested, or 2) when there is a question regarding a currently privileged provider's ability to provide safe, high quality patient care.

II. Definitions:

A. **External Review** is a review conducted by an unbiased physician or other practitioner in an appropriate specialty or subspecialty who is actively in practice or has recently retired, but who is not a member of the Medical Staff.

B. **Focused Review or Focused Professional Practice Evaluation (FPPE)** is a time-limited process whereby the Medical Staff evaluates the privilege-specific competency of the Providers or the Providers' ability to provide safe, high quality patient care.

C. **Peer Review** is the objective measurement, assessment and evaluation by Peer Reviewers or Peer Review Committees, of the quality of care provided by individual Providers, as well as the identification of opportunities to improve care and report the Committee's conclusions and recommendations to other Peer Review Committees and/or the Medical Executive Committee for appropriate action.

D. **Peer Review Committee** is a department, committee or subcommittee charged under the Medical Staff Bylaws with responsibility for conducting Peer Review.

E. **Peer Reviewer** is a qualified practitioner who performs Peer Review and who possesses the appropriate clinical judgment based on training, education, and experience.

F. **Provider** includes any Practitioner who is credentialed and privileged through the Medical Staff process at Banner facilities.

III. Policy:

A. The Medical Staff will assess Provider performance and support patient safety and quality improvement initiatives. This applies to all Providers privileged through the Medical Staff process at Banner Health.

B. FPPEs are conducted for new applicants and newly requested privileges by current Providers. FPPEs may also be conducted for a single incident or evidence of a clinical practice trend.

C. FPPEs and all subsequent action, including corrective action, is conducted pursuant to Medical Staff Bylaws, Rules and Regulations, and/or Policies and Procedures.

D. FPPE requirements including observation/retrospective review will be imposed in accordance with Medical Staff documents.

E. Criteria/Triggers for FPPE may include, but are not limited to:
   1. Reported concerns about care, conduct or competence, for example two Peer Review Scores of a Level 3 or 4 within six months.
   2. Receipt of credible information suggesting one or more concerns, such as a licensing board letter of censure, Risk Management information, or action by other hospitals.
   3. Granting of new privileges, whether to a new or current Provider.

F. Monitoring Plan for a Focused Review:
   1. Peer Review Committees, including the Medical Staff Executive Committee, are responsible for developing and approving the monitoring plan.
   2. The measures employed to resolve performance issues or establish current competency in accordance with Medical Staff documents.
   3. The period of performance monitoring to further assess current competence is based on the evaluation of a Provider's current clinical competence, practice behavior, and ability to perform the granted privilege.
   4. The monitoring time period can be extended and/or a different type of evaluation process assigned.
   5. Results of the monitoring are reported to the appropriate Peer Review Committees and/or department chairman for final recommendation.
   6. FPPE will be consistently implemented in accordance with the criteria and requirements defined by the Medical Staff.
   7. Cases meeting the criteria for reviewable circumstances will undergo review, according to approved Medical Staff process.
   8. FPPEs will be completed in accordance with the timelines established by the Medical Staff.
   9. Circumstances may arise in which the review process must be expedited. This includes cases meeting the definition of a serious reportable event. (See Event Policy) The review will follow the process as provided in the Medical Staff Bylaws or Allied Health Professional Policy.

IV. Procedure/Interventions:

A. Implement FPPE for new and current Providers who request new privileges. **(MSS/QM)**

B. Request a Focused Review, as appropriate. **(Medical Staff Officers, Peer Review Committee, Department Chair or Vice Chair, the CEO or the CMO)**

C. Return the FPPE report directly to Medical Staff Services. **(Reviewers/Committees)**

D. Present results to the appropriate Peer Review Committee. **(Department Chair or Vice Chair)**

E. When applicable, inform the Provider of any findings and any recommended actions. **(Peer Review Committee)**

F. Place results of FPPE in the Provider's confidential credentials file. **(MSS)**

G. Take Corrective Action as warranted in accordance with the Medical Staff Bylaws. **(Peer Review Committee)**

H. Notify appropriate staff of any changes to existing privileges in accordance with the facility's notification process. **(MSS)**

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. **CRITERIA FOR DETERMINING TYPE OF MONITORING**

1. Criteria to consider when determining a type of monitoring to be conducted include, but are not limited to, the following:

Criteria to Determine Monitoring Method	Methods of Monitoring	Special Considerations
Issues Identified with: ☐ Documentation ☐ Procedural Privilege ☐ Cognitive Skill Privilege ☐ Interpersonal/ Communication Skills/Professionalism	☐ Chart Review ☐ Direct Observation ☐ Monitoring of diagnostic and Treatment techniques and Clinical practice patterns ☐ Simulation ☐ Proctoring ☐ External Review ☐ Discussions with other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing/patient care services and administrative personnel	The appropriate Peer Reviewer shall, whenever possible, be one who is not a partner of the Provider being reviewed and who does not have any financial arrangements with the Provider to be reviewed, and no conflict of interest exists. Indications for an External Review may include, but are not limited to: a. Lack of internal expertise such as clinical specialists with training in new technology or knowledge of best practices and expectations. b. Lack of internal resources due to, for example, specialists' unavailability, conflicts of interest or reluctance to perform review. c. Ambiguity of conclusions from earlier reviews, because they, for example, conflict or were inadequately specific. d. Lack of credible findings due to possible conflicts of interest potentially affecting prior reviews, conclusions. e. Legal concerns such as when due process action is expected. f. Bench marking, such as when external sources are needed to identify best practices or expectations. A request for External Review must be made to the Provider's department chair, a Peer Review Committee

		chair or the Medical Staff Executive Committee. The request may be made by a Medical Staff officer, the CEO or the CMO. The Provider under review may make a request for an External Review to the Medical Staff Executive Committee, which it may grant at its discretion. The Peer Review Committee chair or a Medical Staff officer will select the External Reviewer. An External Review may be requested at any reasonable time, including, for example, prior to a Focused Review. The Medical Staff Executive Committee will be advised of the request for External Review as well as the conclusions and recommendations of the External Reviewer. A contract will be entered with the External Reviewer before the medical records or other information is shared. Refer to the facility policies for issues related to professional behavior, health, or interpersonal communication issues.
□ Provider Health and/or Behavior Concerns will be referred to the appropriate cte		

VII. References:

A. The Joint Commission Standards MS.08.01.01
B. Triggers Guidelines
C. Medical Staff Ongoing Professional Practice Evaluation Policy

VIII. Other Related Policies/Procedures:

A. Medical Staff Ongoing Professional Practice Evaluation Policy
B. Facility Peer Review Policy
C. Facility Professional Conduct Policy
D. Patient Complaint, Discrimination and Grievance Policy (#2865)
E. Event Reporting Policy (#9062)
F. Complaints of Sexual Harassment or other Prohibited Conduct by Medical Staff Members (#3165)

G. Facility Professional Health/Wellness Policy
H. Medical Staff Bylaws at each facility
I. Fair Hearing and Appeals Process within the Medical Staff Bylaws at each facility
J. Guidelines for the Initiation of Focused, Comprehensive, and External Peer Review

IX. Keywords and Keyword Phrases:

A. Focused Reviews
B. Peer Review
C. FPPE
D. OPPE

X. Appendix:

A. N/A