Texas Health Harris Methodist Hospital SOUTHLAKE	**Policy Area:** Medical Staff
Name of Policy: Professional Practice Evaluation	**Replaces Policy Dated:** **NEW VERSION** (Replaces Physician Performance Plan (Archived)
Pages: 5	**Effective Date:** June 20, 2018

I. PURPOSE

To establish the process whereby the Texas Health Harris Methodist Hospital Southlake (TH Southlake) Medical Staff evaluates the current and ongoing privilege –specific competency of practitioners granted clinical privileges.

II. POLICY

A. TH Southlake Hospital Medical Staff, as part of its ongoing commitment to quality, shall evaluate the competency and professional performance of all credentialed practitioners granted clinical privileges or practice prerogatives (hereinafter referred to as “Privileges”).

B. Medical Staff requesting privileges for the purpose of “call coverage” only will begin FPPE process once first case is completed. In the event there is limited or insufficient volume for assessment, physician may remain on extended FPPE until reappointment.

C. Definitions

1. Focused Professional Practice Evaluation (FPPE): A time-limited period not to exceed six (6) months whereby the Medical Staff evaluates the competency and professional performance for practitioners with initially granted privileges, modification of existing privileges or when concerns are raised regarding an existing practitioner's ability to provide safe and quality patient care.
2. Ongoing Professional Practice Evaluation (OPPE): The process whereby the Medical Staff continuously evaluates competency and professional performance practice trends that impact patient safety and / or quality of patient care.
3. Credentials Committee (CC): A multidisciplinary medical staff committee responsible for managing the evaluation process for all credentialed practitioners granted clinical privileges.
4. Practitioner: Member of the medical or allied health professional staff that has been granted clinical privileges.
5. Professional Practice Evaluation / Evaluation Process: The period or process of either a focused or ongoing evaluation of competency and professional performance for practitioners granted clinical privileges.

III. PROCEDURE

A. General Procedures

1. The Credentials Committee is charged with the responsibility of monitoring and maintaining compliance with this policy. It accomplishes this by receiving regular reports regarding FPPE's from the Medical Staff Office.

2. At the conclusion of the FPPE process, adverse findings will be forwarded to the Credentials Committee for review and recommendation.
3. Adverse results and recommendations from the Credentials Committee shall be forwarded to the Medical Executive Committee (MEC). Recommendations may include moving forward with OPPE, extending the period of FPPE or recommending to limit, suspend or revoke the privileges requested.
4. The MEC's recommendation shall be forwarded to the Board of Managers for final action.
5. Lack of adverse finding shall result in immediate approval of the requested privilege(s).
6. Recommendations of unsatisfactory evaluation or lack of demonstrated competency may result in the reduction, suspension revocation or denial of the requested privilege(s). In the event a practitioner does not have sufficient volume to satisfy FPPE or other evaluation requirements, the Credentials Committee may recommend an extension or for the practitioner to voluntarily resign.
7. External resources may be utilized involving evaluations that raise concerns regarding potential conflict of interests or the lack of the necessary specialty or appropriate level of experience / skill.

B. Focused Professional Practice Evaluation (FPPE)

1. FPPE shall be for a time-limited period not to exceed six (6) months beginning on the first day privileges were granted and will include the evaluation of at least five (5) patient encounters comprised of and within the scope of the privileges granted. FPPE shall be performed under the following circumstances:
   a. New practitioners with initially granted privileges
   b. Current practitioners requesting modification of existing privileges and/or privileges to perform new or rarely performed procedures
   c. When questions and / or concerns are raised through either the OPPE process, individual case review or other peer review process regarding a practitioners competency or professional performance that may affect the provision of safe, high quality patient care.

   Note Exception: For Physicians on staff for “call coverage only”, FPPE will be evaluated every 6 months until volume is reached..
2. Upon the conclusion of the FPPE process, each practitioner will automatically be placed on OPPE following the next scheduled Credentials Committee, Medical Executive Committee and Board of Managers meetings if all requirements are met.
3. If volume requirement is not met, the practitioner will automatically remain on FPPE but may not extend beyond the practitioner’s first reappointment date.
4. If any requirement other than volume is not met, and requires specific action by the practitioner, written notice will be sent.

5. The practitioner is not entitled to hearing and appeal or other procedural rights for any privilege that is voluntarily relinquished.
6. Monitoring criteria, including specific performance elements, thresholds and / or triggers, are developed and approved by the medical staff or Credentialing Committee. Triggers are defined as potentially unacceptable levels of performance. Triggers may include, but are not limited to:
   a. A sentinel event
   b. A single egregious case or evidence of a practice trend
   c. Exceeding the predetermined thresholds established for OPPE
   d. Verified patient / staff complaints
   e. Non-compliance with Medical Staff Bylaws, Rules & Regulations and / or Hospital Policies & Procedures
   f. Elevated infection, mortality and / or complication rates
   g. Failure to follow established clinical practice guidelines
   h. Unprofessional and / or disruptive behavior
7. The results of the individualized practitioner report(s) are referenced in the respective medical staff committee minutes arid maintained in the practitioners quality file.

C. Ongoing Professional Practice Evaluation (OPPE)

1. OPPE shall begin immediately following satisfactory completion of the FPPE process. Ongoing evaluation shall be performed and reported at least every six (6) months for the purpose of assessing a practitioner's clinical competence, professional behavior and to identify professional practice trends that impact quality of care and patient safety. Ongoing evaluation is incorporated into the review and recommendation process for approval of maintaining existing privileges, modifying existing privileges or to limit, suspend or revoke existing privilege(s) prior to and / or at the time of reappointment.
2. This process includes, but is not limited to:
   a. The evaluation of a practitioner's professional performance;
   b. Utilization of multiple sources of information such as the review of individual cases / procedures, the review of aggregate data, compliance with hospital policies, medical staff bylaws and rules & regulations, clinical standards and the use of rates compared against established benchmarks; and
   c. Individual evaluation based on generally recognized standards of care.
3. In the event a practitioner's activity has not been sufficient to meet OPPE requirements, he / she may:
   a. Voluntarily resign; or
   b. Submit a written request for an extension of the period of focused evaluation. Subject to the approval of the Board of Managers, the period of OPPE may be extended as necessary at the discretion of the Credentialing Committee or the MEC, but may not be extended beyond the practitioner's reappointment date.

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

5. This process provides practitioners with feedback for personal improvement and / or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

6. 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 may include, but are not limited to:
   a. A sentinel event
   b. Defined number of events occurring
   c. Defined number of individual peer reviews with adverse determinations
   d. Elevated infection, mortality and / or complication rates
   e. Increasing lengths of stay in comparison to peers
   f. Increasing number of returns to surgery
   g. Frequent unanticipated readmission for the same issue
   h. Patterns of unnecessary utilization of diagnostic testing / treatments
   i. Failure to follow established clinical practice guidelines
   j. Non-compliance with Medical Staff Bylaws, Rules & Regulations and / or Hospital Policies & Procedures

7. During the course of OPPE, a FPPE may be triggered by, but not limited to, the following:
   a. A sentinel event
   b. A single egregious case or evidence of a practice trend
   c. Exceeding the predetermined thresholds established for OPPE
   d. Verified patient / staff complaints
   e. Non-compliance with Medical Staff Bylaws, Rules & Regulations and / or Hospital Policies & Procedures
   f. Elevated infection, mortality and / or complication rates
   g. Failure to follow established clinical practice guidelines
   h. Unprofessional and / or disruptive behavior

8. The results of the individualized practitioner report(s) are referenced in the respective medical staff committee minutes and maintained in the practitioners quality file.

E. Data Collection

1. The type of data collected and related thresholds or triggers is determined by the Credentialing Committee and approved by the Medical Staff.

2. Indicators may change as deemed necessary / appropriate by the Credentialing Committee or the MEC and should be reviewed as often as necessary to ensure current and relative data is collected and reviewed.

3. The Medical Staff is responsible for selecting general indicators that apply to all credentialed practitioners.

4. The Medical Staff may consider using the following six areas of Core Competencies developed and utilized by the Accreditation Council for Graduate Medical Education (ACGME):
   a. Patient Care
   b. Medical Knowledge
   c. Practice-Based Learning and Improvement
   d. Systems Based Practice
   e. Professionalism
   f. Interpersonal Skills & Communication
5. Methods and information utilized in the evaluation process may include, but are not limited to:
   a. Concurrent / retrospective medical record review
   b. Proctoring and I or direct observation
   c. Internal / external peer review I discussion with other care-team members
   d. Routine monitoring of service specific indicators
   e. Complaints / concerns from patients, staff, medical staff members, etc.
   f. Deviation from established clinical practice guidelines
   g. Operative & other invasive procedure(s)
   h. Morbidity & mortality data
   i. Patient safety data / Use of unapproved abbreviations
   j. Use of blood & blood components
   k. Use of medications
   l. Occurrence reports
   m. Sentinel events and / or near misses