



**Medical Staff and Advance Practice Provider
Focused Professional Practice Evaluation for New
Privileges and Ongoing Professional Practice Policy**

I. PURPOSE

To establish a systematic process to ensure current competency of medical staff and advanced practice providers in three circumstances:

- Practitioner has been granted initial new privileges (FPPE, Focused Professional Practice Evaluation);
- Practitioner with existing privileges has been granted an additional new privilege (FPPE);

OR

- Practitioner is exercising current privileges (OPPE, Ongoing Professional Practice Evaluation).

FPPE is required for all practitioners with newly granted privileges, and OPPE is required for all practitioners with ongoing privileges.

II. MEDICAL STAFF OVERSIGHT OF FPPE

The Medical Executive Committee (MEC) is charged with the responsibility of monitoring compliance with this policy and procedure. It accomplishes this oversight by receiving regular status reports related to the progress of all practitioners under evaluation as well as any issues or problems involved in implementing this policy and procedure. The Department Chair shall be responsible for overseeing the evaluation process for all applicants with new and ongoing privileges assigned to his/her department.

The Clinical Departments involved with FPPE will, through their Chair, provide the Credentials Committee with a copy of the FPPE plan and a summary evaluation form upon the completion of the focused review period.

All recommendations arising out of the FPPE process are sent from the Department Chair to the Credentials Committee, to the Medical Executive Committee, and to the MCHS Credentialing Subcommittee of the Quality and Safety Committee of the Board of Trustees for final approval and action, as appropriate.

III. SCOPE OF THE FPPE PROGRAM

Definition and Expectations of FPPE:

For purposes of this policy, FPPE is a focused evaluation to confirm an individual practitioner's current competence at the time when he or she requests new privileges, either at initial appointment as a current member of the Medical Staff, or as an Allied Health Professional. In addition to specialty-specific issues, this evaluation also will address the six general competencies of practitioner performance:

- A. Patient care
- B. Medical/clinical knowledge
- C. Practice based learning and improvement
- D. Interpersonal and communication skills
- E. Professionalism
- F. System-based practice

Practitioners requesting membership but not exercising specific privileges do not need to undergo FPPE.

Qualifications of FPPE Evaluator(s):

Members of the Medical Staff with unrestricted similar privileges, can act as FPPE evaluators. Evaluation by more than one individual is recommended whenever possible. An evaluator can be a new practitioner's partner, but not a first degree relative (parent, son or daughter, spouse or sibling). If a question of evaluator bias or conflict of interest arises, and the Department Chair cannot resolve the concern, the determination of whether a given member of the Medical Staff can serve as the evaluator for another member of the Medical Staff will be made by the Credentials Committee. The MEC and the Credentials Committee must review and, as necessary, resolve any conflict of interest and its potential impact on the integrity of the evaluation process. The MEC and the Credentials Committee, serving as review bodies, must have full knowledge of any conflict of interest when evaluating the FPPE results.

Process for Selection of an FPPE Evaluator:

Concurrent with applying for privileges, a new applicant to the Medical Staff, an existing member who is requesting a new privilege, or an Allied Health Professional will provide the names of one or more members of the Medical Staff whom he/she requests to serve as their evaluator. This request will be made on the application for new privileges. Preferably the practitioner will have spoken to the potential evaluator(s) prior to submitting their name(s) for consideration. For some hospital-based specialties such as Emergency Medicine, at the Chairman's discretion, the practitioner may write "other members of the Department."

The Department Chair will review this request and make a recommendation to the Credentials Committee to approve this request or not. If the Department Chair does not recommend the evaluator requested, he/she will recommend a different individual to the Credentials Committee. If the practitioner does not provide the name of a potential evaluator, the Department Chair will recommend an appropriate practitioner to the Credentials Committee. The final approval of the evaluator will be made by the Credentials Committee.

Medical Staff's Obligation to Serve as Evaluator for FPPE:

All Medical Staff members with privileges are expected to serve as FPPE evaluators if requested by the Department Chair.

The FPPE Evaluator's role is not to serve as a consultant or mentor. A practitioner serving solely as an evaluator, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the hospital.

The evaluator shall receive no compensation for this service, and he/she shall have no duty to the patient to intervene in the care provided by the evaluated practitioner unless care is deficient or appears to be deficient.

The evaluator or any other practitioner may render emergency medical care to the patient for medical complications arising from the care provided by the evaluated practitioner. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his/her acts or omissions in the role of evaluator.

Use of Non-physicians, Vendors, and External Evaluation:

1. Indications to Consider External Evaluators:

The Department Chair, with the approval of the Credentials Committee Chair, may ask for and utilize external physicians (outside of MCHS) as evaluators when:

- A. The procedure is new to the organization and no current Medical Staff member currently has the privilege;
- B. The only available Medical Staff member is an economic competitor, raising a potential conflict of interest; or
- C. Use of available Medical Staff members would compromise the goal of a fair, balanced, and educational evaluation experience.

Non-physicians (vendors, nurses) may be used as trainers to support evaluating, but do not substitute or replace the FPPE evaluator.

2. Qualifications of External Evaluator:

The external evaluator must:

- A. Be a licensed physician. If the evaluation requires hands-on interaction with the patient, directing care, or providing verbal supervision, the evaluator must be licensed in the State of Ohio. If the evaluation requires reviewing competence as part of peer review (which would be the goal of FPPE for New Privileges), the evaluator can be licensed in another state. State licensure will be verified directly with the licensing state.
- B. Currently have the privilege at his/her primary hospital. The Medical Staff office will obtain verification of affiliation and privileges and a reference from the physician's Department Chair.
- C. Provide evidence of malpractice insurance coverage. A National Practitioner Data Bank query will be performed on all evaluators.

3. Process for External Evaluation:

- A. All conditions of Item 2 above must be met and verified prior to the scheduling of the procedure by the requesting physician.
- B. The evaluation information identified in Item 2 above must be reviewed and approved by the Department Chair and the Credentials Committee Chair. .
- C. Both the Medical Staff member and the evaluator (if non-staff member) must obtain privileges in order to perform new procedures or use new technology. Temporary privileges must be granted according to the policy for the purpose of performing specific procedures during the FPPE evaluation process.

Evaluation Methods:

Evaluation may be performed using multiple methods:

- A. direct observation
- B. prospective or retrospective case review
- C. simulation
- D. clinical quality data review and/or
- E. discussion with other individuals involved in the care of each patient, including consulting practitioners, allied health professionals, surgical assistants, nurses, and administrative personnel.

Specialists who most often provide cognitive care, as opposed to procedural care, will usually be evaluated with prospective and/or retrospective case review, and clinical quality data review.

Practitioners who request procedural privileges will usually be evaluated by prospective and/or retrospective case review, quality data review, and direct observation.

Duration of FPPE Evaluation:

Evaluation period shall begin with the applicant's receipt of the newly requested privilege. Newly granted privileges will usually be considered under FPPE for a specific number of encounters/procedures, based on the recommendation of the Department Chair, but the Chair may elect to specify a period of time for FPPE evaluation instead of requiring a number of encounters/procedures.

The duration of the initial evaluation period is not to exceed six (6) months, and may not be less than three (3) months. The Department Chair may extend an FPPE once for a period not to exceed six (6) months.

Characteristics of FPPE Plan:

The FPPE Plan must be individualized by the Department Chair, with consideration of the practitioner's training and experience and the privilege being requested. Regardless of qualifications, anyone granted new privileges must undergo FPPE.

The FPPE Plan can include multiple methods of evaluation, but procedural privileges for practitioners new to MCHS must include direct observation as a component of FPPE at their primary hospital. The Department Chair can choose to specify that up to half of the required numbers for procedural observation can be met by simulation (formally observed and recorded experience in the Mount

Carmel Simulation Lab program).

For Core Privileges or other grouped privileges, it is expected that the total number of cases or encounters will be representative, not all of one type, and the Department Chair will assess whether the cases evaluated are adequately representative. For level 2 and 3 privileges the total number of cases will be representative and may not include all privileges. Some applicants will have requested educational proctoring for specific privileges. Educational proctoring does not count towards FPPE evaluation. FPPE begins as soon as the applicant is credentialed, but for privileges in which educational proctoring is requested, cases for FPPE will not begin to accrue until the educational proctoring requirements are completed.

Practitioners who have recently graduated from a MCHS residency training program, or currently hold unrestricted applicable privileges on another Mount Carmel Health System Medical Staff, may require less evaluation, because the organization has had multiple opportunities to directly observe their current competence.

MCHS is a multi-hospital system. As such, a current practitioner may add a new hospital practice site or an additional privilege which is already being performed at an existing practice location. In such instances, the department chairman at the new site will be provided the following: FPPE data if completed within the past 12 months, OPPE data, Quality and Safety data, patient volumes. The chairman will review the data and make one of the following recommendations:

1. Accept the data for FPPE, with the practitioner continuing on OPPE
2. Require a limited FPPE, as specified by the chairman
3. Require that the practitioner complete a new FPPE process

Low Volumes After First Year of FPPE:

After one (1) year of FPPE, if a practitioner has insufficient case or encounter volumes to allow adequate evaluation of the privilege(s) requested, the Credentials Committee may accept evidence of successful evaluation from another MCHS hospital to meet a portion of the FPPE requirements.

If a practitioner has inadequate case or encounter volumes, including all MCHS hospitals, after one (1) year of FPPE, the Department Chair will discuss this with the practitioner and notify them that the privilege will be considered voluntarily withdrawn (not reportable to the National Practitioner Data Bank). The Department Chair will notify the CVO of the discussion with the practitioner.

Unique Circumstances:

Occasionally, a practitioner whose primary practice is outside of MCHS is asked to provide clinically crucial services that are not available within MCHS. Additionally, practitioner providing coverage whose primary practice is outside a MCHS facility need an evaluation of clinical competence.

In these circumstances, the Credentials Committee may elect to accept evidence of successful evaluation from another hospital or ambulatory surgery center (ASC) to meet a portion of the FPPE or OPPE requirements. This arrangement is acceptable only under the following circumstances;

1. The practitioner to be evaluated is responsible for identifying the hospital or ASC where information may be obtained and assure that the requested information can be forwarded directly from the institution to MCHS.
2. The practitioner must consent to authorize the hospital or ASC to release copies of his/her

observation (evaluation) reports or a summary of evaluation activities including any conclusions, recommendations or decisions.

3. A physician representative of the Medical Staff organization at the hospital or ASC must complete the "Reciprocal Observation Evaluation Summary" form and forward to the Medical Staff Office of MCHS.
4. The hospital or ASC must provide MCHS with a copy of the clinical privileges that have been granted to the practitioner who needs evaluation.
5. It is with the discretion of the Department Chair to determine whether the observation at the hospital, or ACS, meets the requirements of MCHS. The Department Chair's decision will be reviewed by the Credentials Committee, MEC(s), and Credentialing Subcommittee of the Quality and Safety Committee of the Board of Trustees.

Once the information has been received from the hospital or ASC, the Department Chair makes his/her recommendation and the evaluation and decision-making process proceeds through the Credentials Committee and MEC.

FPPE Process:

The process of FPPE evaluation for new privileges is outlined in Appendix A.

IV. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

- A. Purpose. The Mount Carmel Health System Performance Improvement and Quality Assurance program initiatives are designed to (1) continuously improve the quality of care to patients of Mount Carmel Health System; and (2) provide clearly defined professional practice evaluation processes to determine the current competency of privileged Physicians and Advanced Practice Professionals (APPs) to provide high quality, safe patient care in the hospital.

Pursuant to these initiatives, review of a practitioner's performance shall be conducted by the practitioner's peers (or selected consultants to the Medical Staff) in a manner consistent with this policy.

- B. Process. The Medical Staff conducts continuous ongoing quality oversight of Practitioners/APPs professional practice intended to provide useful information in the areas of patient care, professionalism, practice-based learning and improvement, interpersonal and communication skills, system-based practice patient care, and medical/clinical knowledge. This information/data assists the Medical Staff, Practitioners, and APPs to identify individual practice trends that may affect patient care and safety. This information/data is also used in privileging decisions specific to that Practitioner/APP.

- C. Medical Staff Oversight of OPPE. The Medical Executive Committee (MEC) is charged with the responsibility of monitoring compliance with this OPPE policy and procedure. It accomplishes this oversight by receiving regular status reports on all practitioners under evaluation as well as any issues or problems involved in implementing this policy and procedure. The Department Chair shall be responsible for overseeing the evaluation process for all applicants with ongoing privileges assigned to his/her department.

All recommendations arising out of the OPPE process are sent from the Department Chair to the Credentials Committee, to the Medical Executive Committee, and to the MCHS Credentialing

Subcommittee of the Quality and Safety Committee of the Board of Trustees for final approval and action, as appropriate. Any identified issues of individual practitioners regarding quality or performance are referred to the appropriate Peer Review Committee for further evaluation.

D. Data. Data compiled for purposes of OPPE may include as appropriate, but not limited to, the following:

- Clinical performance
- Review of indications for, and performance of, operative and other clinical procedure(s) performed and related outcomes
- Pattern of blood and pharmaceutical usage
- Quality Measure Compliance
- Utilization review
- Appropriateness of clinical practice patterns and practices
- Significant departures from established patterns of clinical practice
- Autopsy results and criteria
- Medical assessment and treatment of patients
- Morbidity and mortality data
- Practitioner's use of consultants
- Patient Experience results
- Citizenship and professionalism
- Accuracy, timely and legible completion of medical records
- Coordination of care, treatment and services with other practitioners and hospital personnel
- Sentinel event data
- Patient safety data
- Core indicators and Department-specific indicators as determined by the Medical Staff in collaboration with the applicable Department Chair
- Other relevant criteria as determined by the Medical Staff

E. Compilation of Data. Data may be acquired through the following sources, but not limited to:

- Routine chart audits by non-medical staff personnel for important clinical functions
- Direct observation
- Findings from Hospital Performance Improvement and/or Quality Assurance reports
- Results of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting practitioners, clinical assistants, nursing staff, administrative personnel, etc.
- Data abstracted for external comparative databases used to evaluate Practitioners
- Data from Serious Safety Events, Apparent Cause Analysis and Learning from Defects
- Incident reports, complaints, and compliments
- Findings of cases identified for review by Medical Staff Peer Review committees
- External Peer Review
- Patient satisfaction surveys

OPPE criteria are reviewed periodically by the Clinical Quality Management Division with input from the clinical Department Chairs. The OPPE criteria are forwarded to the MPRC and then to the MEC for approval.

F. Review of OPPE Data/Information.

- OPPE shall be conducted bi-annually (twice per year) by the Department Chair and/or Service Chief. OPPE information is intended to reflect individual practitioner performance that is compared to prior reports to evaluate ongoing competency.
- OPPE results shall be documented (including an electronic OPPE review system). The Clinical Quality Management Division will assist in facilitating the OPPE process and monitor OPPE review compliance.
- In the event a Department Chair identifies that an OPPE indicates opportunities for improvement and/or concerns, the Department Chair is encouraged to meet with the affected Practitioner/APP to provide mentoring and direction.
- When necessary, the OPPE review may result in a Department Chair's recommendation to assign a period of Focused Professional Practice Evaluation (FPPE) monitoring to further assess current competence or a recommendation to initiate a separate corrective action process of the Medical Staff. In this instance, the Department Chair will forward this recommendation to the MPRC for review and appropriate action.
- The Department Chair shall forward a report to the appropriate MPRC with recommendations in the event further action may be necessary regarding a decision to continue, modify or restrict any existing privileges in accordance with the process defined in the Medical Staff Bylaws.

G. OPPE for Low Volume/No Volume.

If after two (2) cycles of OPPE a Practitioner has insufficient case or encounter volumes (including all MCHS hospitals) to allow for adequate evaluation of competency of the Practitioner's privileges, the Department Chair is encouraged to meet with the affected Practitioner to inquire about the need to maintain specific clinical privileges.

In those circumstances where a Practitioner's primary clinical practice is outside of MCHS, and the Practitioner is asked to provide clinically crucial services that are not available within MCHS, OPPE data/information may be accepted from another hospital or ambulatory surgery center as defined in Section III – Unique Circumstances of this policy.

Revised Policy & Process presented for review and approval

Reviewed by:
Medical Staff Credentials Committee May 11, 2017

Approved by:
Medical Executive Committees

MCNA	May 15, 2017
MCSA	April 17, 2017
MCH	April 18, 2017

Credentialing Sub-Committee of the Quality & Safety Committee
of the MCHS Board of Trustees May 22, 2017