

**HUDSON HOSPITAL & CLINICS
POLICY AND PROCEDURE**

Title: Ongoing Professional Practice Evaluation
Policy Number: 902
Category: Medical Staff
Review Coordination Responsibility: Manager, Quality

I. POLICY: The Medical Staff of Hudson Hospital & Clinics provides effective mechanisms to monitor, assess, and evaluate the appropriateness and quality of patient care, care and clinical performance of all individuals credentialed to provide patient care. Evaluation of professional practice of medical staff members is delegated by Credentials Committee to MSQI Committee and is conducted at initial appointment, reappointment and ongoing through focused evaluation, including peer review. The scope of the ongoing professional practice evaluation (OPPE) program includes credentialed medical staff members and allied health practitioners and consists of peer references, peer review, proctoring and/or ongoing evaluation of identified circumstances for review. The data and information gathered during the review and evaluation process are deemed confidential and not subject to discovery pursuant to Wisconsin Statutes. It is expected that, when appropriate, references to literature and relevant clinical practice guidelines will be used in the review and evaluation process. OPPE data is utilized by MSQI, Credentials Committee, and the Medical Executive Committee to inform privileging decisions.

II. DEFINITIONS:

A. General Competencies for Practitioners: Basic expectations for competency of practitioners are defined into the following categories as a framework for measurement and evaluation of practitioner performance:

1. **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life
2. **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and apply of their knowledge to patient care and the education of others
3. **Practice Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care
4. **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams
5. **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society
6. **Systems Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare

- B. Focused Professional Practice Evaluation (FPPE):** Evaluation to determine privilege specific competency for a practitioner that is: (a) initially appointed; (b) requesting modification of privileges; and/or (c) when a question arises about a practitioner's ability to provide safe high quality care and/or service.
- C. Ongoing Professional Practice Evaluation (OPPE):** Ongoing monitoring and assessment of a practitioner's ability to meet the general competencies, expectations and peer review of established criteria for current medical staff members and allied health staff members.

A practitioner's performance is continuously evaluated. This ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. It is inclusive of the Focused Professional Practice Evaluation process.

- D. Peer:** Another practitioner with essentially the same privileges and qualifications as the clinical privilege and/or performance that is being reviewed.
- E. Peer Review:** The evaluation of an individual practitioner's professional performance, which includes the identification of opportunities to improve care or service.
- F. Peer Review Referral:** An incident, situation, or complaint presented to the MSQI Committee which requires: evaluation of the quality of care provided; an investigation into an adverse outcome for a patient; review of an existing system issue or process that requires improvement. The results of the referral are shared with the Medical Executive Committee and Credentials Committee as appropriate.
- G. External Peer Review:** The study, review, investigation, evaluation and/or assessment of the training, experience, skill, professional conduct, qualifications and/or current competence of one or more Medical Staff members referred to an individual who are not Medical Staff members but who have the same professional licensure as the review subject and who are in the same or a similar specialty as the review subject.

H. Peer Review Definitions

- 1. Exemplary Care:** Care and documentation which exceed expectations.
- 2. Adequate Care:** Care, documentation, and communications which are appropriate for patient. No deficiency identified.
- 3. Minor Communication Issue:** Adequate care but minor communication issues apparent which can be improved upon.
- 4. Minor Care Issue:** Care identified as having minor, correctable issues that do not contribute to poor patient outcomes.
- 5. Quality Issue:** Some aspects of patient care do not meet standard of care.
- 6. Deficiency in Care:** The event or outcome involved a major error in diagnosis, management, judgment, or technique.

III. PROCEDURE: The ongoing professional practice evaluation is implemented for all practitioners granted privileges throughout their appointment/reappointment period. This ongoing review allows the Hudson Hospital & Clinics Medical Staff to identify professional practice trends that may impact the quality of patient care and patient safety. Results of the ongoing professional practice evaluation are considered in decisions for reappointment. The MSQI Committee is responsible for assuring the Medical Staff, through its Chief of Staff, and the Medical Staff Departments and Committees develop criteria for ongoing professional practice evaluation. Annually, the MSQI Committee selects indicators to identify potential care/service variances. Additional quality indicators are developed that assist in the identification of opportunities for improvement related to established best practice. Variances from established criteria require peer review. Relevant information is also integrated with organizational performance improvement activities and the medical staff peer review system into a Physician Quality Profile. Individual Physician Quality Profiles are reviewed on a semi-annual basis for potential trends/patterns and statistical validity. If review indicates the need for peer review and/or potential FPPE, results are forwarded to the MSQI Committee. The Quality Department, not less than semi-annually, forwards all practitioners' OPPE results to the MSQI Committee.

A. Focused Professional Practice Evaluation:

1. A period of focused professional practice evaluations is implemented for all initial appointments and privileges during the 6 month provisional period. During this provisional period, data and information to determine competency includes evaluation of the six general areas of competencies and the ability to perform the privileges requested. The MSQI Committee and Credentials Committee establish the criteria and plan for performance monitoring that may include chart review; monitoring clinical practice patterns; simulation; proctoring; external review; and peer references. Additionally, information contained in the Quality profile is considered in decisions to advance practitioners to full staff membership.
2. A focused professional practice evaluation may also occur as a result of single trends and/or clinical practice trends observed during the practitioner's appointment period as part of the ongoing professional practice evaluation period that is implemented as part of every practitioner's appointment period. These cases are forwarded to MSQI for review.

B. Peer Review Process:

1. The Hudson Hospital & Clinics MSQI Committee is responsible for conducting an effective peer review process to support focused and ongoing professional practice evaluation. The peer review system is based on the following attributes:
 - a) **Consistency:** The peer review process is conducted according to defined procedures for all circumstances;
 - b) **Timeliness:** Time frames outlined in this policy are reasonably adhered to;
 - c) **Defensible:** Conclusions reached through the peer review process are supported by rationale that specifically discusses the issues for which the peer review was conducted, including, when appropriate, references to literature and clinical practice guidelines;
 - d) **Balanced:** Minority opinions and the views of the reviewed are welcomed
 - e) **Useful:** Results of peer review are considered in practitioner specific credentialing and privileging decisions and, when appropriate, integrated with the organizational performance activities.

- f) **Ongoing:** Peer review conclusions are tracked over time and actions based on peer review conclusions are monitored for effectiveness.
It is the responsibility of the MSQI Committee and the Medical Staff to ensure the process is applied uniformly and that the findings and actions of the reviews are reported to the appropriate bodies.
- 2. All active, emergency and consulting medical staff members shall participate as reviewers in the peer review process. Two times per year, each provider will complete peer review of a colleague with privileges in the same specialty.
- 3. Additional circumstances which require peer review include a variance or occurrence from the uniform screening criteria. A first level review is conducted by the Quality Department and/or staff responsible for coordinating the clinical function and is conducted within thirty days of the care provided, or the variance is identified when possible. If the first level review requires a medical peer review, the case is referred to the MSQI Chair to determine the appropriate peer reviewer.
- 4. If the documentation in the record supports the occurrence/event, and no evident opportunity for improvement is identified, the case is considered appropriate and no further action is warranted. A copy of the review is filed in the individual practitioner's quality file.
- 5. If the results of the review identify an opportunity for improvement or deficiency in care, the attending/involved practitioner is notified by the MSQI Chair and provided the opportunity to submit any additional information as may be pertinent to the findings. The MSQI Committee makes recommendations for further actions as described in #7.
- 6. Aggregate results of the peer review, including peer reviewer recommendations, are reviewed at the MSQI Committee.
- 7. The MSQI determines any actions or further recommendations to be taken. The MSQI Chair immediately notifies, in writing, the Credentials Committee Chair of actions, recommendations and conclusion reports in the following cases:
 - a) A practitioner with a quality issue or deficiency in care (peer review definitions #4 and #5 – see below);
 - b) A practitioner in a performance improvement plan (with or without modifications or limitations to privileges);
 - c) A practitioner with modifications or limitations to privileges;
 - d) A large volume of communication issues and/or minor care issues (peer review definitions 3.a. and 3.b.below) that are being trended.
- 8. Actions/recommendations may include, but are not limited to, a second review, an outside review, referral to another committee, education, proctoring, focused professional practice evaluations or restriction of privileges.
 - a) The process needs to insure that each physician is notified in writing and in a timely manner (certified and/or a direct signature required to confirm letter has been received)
 - b) The physician is updated about the status of their review at any point throughout the process

D. External Peer Review:

- 1. Circumstances requiring external review include those cases where there is not another practitioner meeting the organization's definition of a peer; if the case has included participation or consultation with the individuals/practitioners conducting the peer review; if

there is a defined conflict of interest present; and/or if the case has a potential for liability and an external review would provide additional objectivity to the findings.

2. External peer review is coordinated through the Quality Department and MSQI. External peer review should be conducted within sixty days of the referral.
3. The process outlined in the Medical Staff Bylaws must be followed when any recommendations/actions taken adversely affect a practitioner's privileges and/or medical staff membership.

E. Confidentiality:

1. Recognizing the importance of preserving the confidentiality of this information, members of the medical staff and hospital staff members appointed to medical staff committees agree to respect the confidentiality of all information obtained in connection with their responsibilities as staff and committee members. This requirement extends not only to the information contained in records and files, but also to the confidential discussions and deliberation that takes place within the confines of medical staff committee meetings or reports to the Board of Directors. The Quality File is accessible to the Chief of Staff, Medical Director and the CEO/President of the hospital or his/her designee. The contents of the quality file are retained for at least a period of seven years.
2. Documentation of the results of peer reviews is placed in the individual practitioner's quality file which is protected under state peer review statutes. The provider's quality file is maintained separately from the credentials file.

F. Evaluation of Effectiveness:

1. The MSQI Committee reviews the peer review policy on an annual basis. The review includes effectiveness of the process, any revision of screening indicators/criteria, and any previously unidentified trends. The effectiveness of actions related to individual practitioners is automatically evaluated at least at the time of reappointment, or more frequently if appropriate.

REFERENCES:

KEY WORDS: peer review, credentials, performance,

RELATED POLICIES:

Original Policy Name, Effective Date, and Review Dates: 5/30/2008, 12/6/2010, 07/29/2013

APPROVAL GROUP(S)	Approval Date(s)	Review/Revision Dates, if Applicable	Effective Date(s)
VP Operations, Chief Integrity & Compliance Officer		2/4/2013	
MSQI	4/9/2008	2/4/2013	5/30/2008
Credentials Committee	4/28/2008	07/15/2013	5/30/2008
Medical Executive Committee	5/6/2008	07/29/2013	5/30/2008