Version #: 11

Title: Focused Professional Practice Evaluation (FPPE)

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Location: Saint Joseph Health System – Mishawaka & Plymouth			Department: Medical Staff Affairs

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POLICY:

1. The organized medical staff has defined the circumstances requiring monitoring and evaluation of a practitioner's professional performance that does not have documented evidence of competency performing the privilege(s) at our hospital. This process is also used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. The FPPE process is time-limited.
2. Evaluation of professional practice will be completed in the following specific circumstances:
   A. A period of focused professional practice evaluation is implemented for all initially requested privileges. This includes:
      1) All new practitioners
      2) All new privileges for existing practitioners
   B. Clearly delineated criteria as defined by the medical staff will be used for evaluation of the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified ("triggered") i.e. A.5.
   C. The FPPE process is delineated as follows:
      1) criteria for conducting performance evaluation
      2) method for establishing the monitoring plan specific to the requested privileges
      3) method to determine the duration of performance monitoring
      4) circumstances under which monitoring by an external source is required
   D. The FPPE process will be implemented consistently.
   E. The decision to assign a period of performance monitoring to further assess current competency is based on evaluation of a practitioner's current clinical competency, practice behavior, and ability to perform the requested privilege. The type of monitoring will be determined by predefined criteria.

PROCEDURE/GUIDELINES:

A. Initially Requested Privileges:

1) Criteria for Conducting Performance Monitoring:
   a) FPPE for practitioners identified below will be evaluated at least the first three months.
      (1) All new practitioners;
      (2) All new privileges for existing practitioners
2) The monitoring plan will be specific to the requested privileges or group of privileges and may include proctoring, as applicable. Review for each practitioner will include review of the following data reports and information by the department/specialty representative.

a) Midas Statit Reports – These reports include inpatient and outpatient data for both the individual physician and comparison with the aggregate of the physicians in that specialty:

(1) Admission Activity

(2) Length of Stay Data (actual and expected)

(3) Mortality Data (actual and expected)

(4) Procedures by ICD

(5) All Risk related occurrences

(6) All Quality Indicator related occurrences

b) Proctoring requirements are delineated and developed according to the Medical Staff Proctoring policy.

(1) Chart reviews-The department chair or designated representative will complete Five retrospective chart reviews including one sedation case if sedation privileges are granted. For new privileges for existing practitioners, five retrospective chart reviews are to be completed when proctoring is not required.

(2) The APNs and PAs will be asked for patient lists for their initial three (3) months for review.

3) Department Chair or Designated Physician Representative will document pertinent findings and recommendations to include:

a) Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety.

b) Request for additional review for an individual practitioner based on an identified issue. Information gathered for review may include, but not be limited to:

(1) Drill down reports

(2) Additional performance of a specific procedure

(3) Additional Monthly Review

(4) Direct Observation

(5) Concurrent Monitoring

(6) Retrospective Chart Review

(7) Discussion with other individuals involved in the care of the practitioner's patients including consulting physicians, assistants at surgery, nursing and administrative personnel.

c) The information gathered will be presented to the Department Chair or Designated Physician Representative to complete.

4) Method for determining the duration of performance monitoring:

a) The above process will continue for at least the first three months of each practitioner's FPPE. The practitioner will then be reviewed for termination of FPPE. Continuation, limitation, or revocation of any existing privileges will then be considered. This will provide a minimum of a three month evaluation period.

b) FPPE data may be obtained from a CMS-certified organization. However, any information received can be used only as supplemental information, not in lieu of collecting organization-specific data.

c) If no activity at the 3 month FPPE review, the practitioner will remain on FPPE and will continue to be monitored monthly. The sponsoring physician will be notified when an APN or PA does not have needed volumes.

(1) If a physician does not have any activity in their first 12 months, they will automatically move to Affiliate Medical Staff Status for administrative purposes. Physicians will be notified one month prior to staff status change. This administrative action does not entitle the physician to appeals.

(2) If an APN or PA does not have any activity in their first 12 months, their privileges and affiliation will automatically expire for administrative purposes. Practitioners and their sponsoring physician will be notified one month prior to staff status change. This administrative action does not entitle the practitioner to appeals.

d) The department chair or designated physician representative may request immediate action according to the Medical Staff Bylaws be taken at any time during the FPPE process, which may include, but not be limited to, forwarding concerns to the following committees:

(1) Credentials Committee for review and/or

(2) Physician Well Being Committee for review, as applicable

(3) Medical Executive Committee

e) Extension of evaluation period will continue until the Department Chair or Designated Physician Representative is either:

(1) Satisfied with the information received and reviewed, or

(2) Recommendations are made to the Credentials Committee or Physician Well Being Committee, as applicable, for review and recommendation to the Medical Executive Committee for action including, but not limited to, the initiation of the Collegial Investigation per the Medical Staff Bylaws Credentials Policy Manual.

5) Criteria for conducting FPPE for those practitioners who need evaluation of their performance as a result of an issue affecting the provision of safe, high quality patient care.

a) Evaluation will take place as soon as a "trigger" is identified. Triggers can be single incidents or evidence of a clinical practice trend.

b) Review will continue, at a minimum, on a monthly basis for the first three months. Triggers will be consistently identified and implemented.

(1) Triggers may include, but are not limited to, data obtained from quality indicators, risk indicators, utilization indicators, unexpected deaths, medical leave of absence, Hospital and Medical Staff Bylaws, Rules & Regulations or policy violations. See Attachment from the Occurrence Monitoring and Peer Review Medical Staff Policy.

(2) FPPE may also be triggered during the OPPE review.

6) Data elements and supporting documentation will be reviewed by the department chair or designated physician representative of each practitioner under FPPE whose review was initiated (triggered) by practice indicators.

7) Administration review, department chair or designated physician representative review and the duration of monitoring will be conducted as outlined in Procedure 1.

8) Circumstances under which monitoring by an external source is required:
   a) Need for specialty review, when there are a limited number or no medical staff members within the required specialty on the medical staff.
   b) The peer review / Credentials Committee is unable to make a determination and requests an external opinion.
9) If behavior is identified as a possible issue at the time of initial appointment of a new applicant or if a behavior occurrence triggers a FPPE, the Medical Staff Code of Conduct Policy will be followed.
10) Upon completion of the above review, evaluation results and recommendation will be presented to the Credentials Committee.

References/Standards:

- Joint Commission Hospital Accreditation Standards (HAS) 2010
- Proctoring And Current Competency Requirements List
- Policy Origin Date: February 2008 (M), February 2008 (P)
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