



MEDICAL AFFAIRS POLICY & PROCEDURE MANUAL

Policy Title:	Medical Staff Professional Practice Evaluation (formerly QRS-02 Medical Staff Quality Assessment and Improvement Program)	Policy Number: MA-01
Approved By:	Medical Executive Committee	October 20, 2015
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POLICY: It is the policy of The Good Samaritan Hospital of Lebanon, PA (The GSH) to comply with statutory and regulatory requirements regarding Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE). This policy replaces Quality and Risk Management’s policy titled “Medical Staff Quality Assessment and Improvement Program”. The organized medical staff is responsible for overseeing and monitoring the quality of patient care, treatment and services rendered by all departments and their members through each department’s Medical Staff Quality Assessment and Improvement (“QA&I”) Committee. The findings of the committees in this policy will be included in the information used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff and on an ongoing basis as appropriate. These committees’ findings will also be forwarded to the appropriate venue for potential system improvements.

PURPOSE: To ensure that the Medical Staff assesses the ongoing professional practice and competence of its members, conducts professional practice evaluation, and uses the results of such assessments and evaluations to improve performance of clinical groups and organization-based systems of care.

Goals:

- a) Monitor practice and performance to identify improvement opportunities for both individuals and systems of care.
- b) Monitor for significant trends in performance by analyzing aggregate data and case findings.
- c) Ensure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and helpful.
- d) Identify and address opportunities for system improvements.

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I. General Information

Throughout this document, the phrase “professional practice evaluation” will be used instead of the traditional phrase “peer review”.

To err is human. Therefore, humans delivering health care will occasionally make errors, and simple human error does not necessarily indicate substandard care or a substandard caregiver. However, we are all responsible for continually identifying and implementing means of minimizing the effects of human fallibility on the care of our patients and for attempting always to further improve the care provided to our patients.

Except in cases of clearly unacceptable care, the Medical Staff organization’s primary goal is to support fellow Medical Staff members in their ongoing efforts to improve their own quality of care; equally important is to assist in identifying and encouraging systematic improvements in our care processes, always with the goal of improving the overall quality of care at The GSH.

The areas of general competency utilized as a basis for Professional Practice Evaluation, credentialing and privileging allow a more comprehensive evaluation of a practitioner’s professional practice which includes the following:

- 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 care at the end of life
- Medical/Clinical Knowledge – practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others
- Practice-Based Learning and Improvement – practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices
- 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
- 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
- Systems-Based Practice – practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care

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II. Definitions

Peer: An individual who is practicing in the same profession and who has expertise in the appropriate subject matter. The Medical Staff Department QA&I Committee designated to perform a review will determine the degree of subject matter expertise required for a provider to be considered a peer for all professional practice evaluations performed by the Medical Staff.

Medical Staff Department QA&I Committee: A peer committee authorized by the Medical Executive Committee (MEC) to pursue the quality improvement goals outlined in this policy and is accountable to the MEC and The GSH Board of Directors for oversight of the professional practice evaluation process.

Ongoing Professional Practice Evaluation (OPPE): A process which allows the Medical Staff to identify professional practice trends and system issues that may affect quality of care and patient safety. The program includes:

- a) The evaluation of systems and processes: identification of issues which may impair optimal provision of care or which do not adequately protect the care process against foreseeable human error.
- b) The evaluation of an individual practitioner's professional performance, including opportunities to improve care based on recognized standards.
- c) Professional practice evaluation is conducted using multiple sources of information, including the review of individual cases, chart reviews, direct observation, monitoring of diagnostic and treatment techniques and discussion with other individuals such as consulting physicians, and nursing; the review of aggregate data (including rate comparisons against established benchmarks or norms); compliance with clinical standards; Bylaws; Rules and Regulations of the Medical Staff and relevant hospital policies.
- d) Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.
- e) The OPPE database is the basic tool used to trend criteria and information developed by the medical staff. OPPE reports are reviewed by the appropriate QA&I committee on a biannual basis. OPPE reports are forwarded to Medical Affairs after the appropriate review and action taken as necessary to be utilized in the reappointment process. Relevant information obtained from the OPPE is integrated into performance improvement activities as needed.

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Focused Professional Practice Evaluation (FPPE): A process to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization (proctoring). It is also a process whereby the Medical Staff more closely evaluates the competency and professional performance of a practitioner when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. FPPE is not considered a formal Medical Staff investigation, and is not subject to regulations afforded in the investigation process.

- a) Focused Professional Practice Evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance.
- b) The time period of the evaluation can be extended, and/or a different type of evaluation process assigned.
- c) Triggers for a focused professional practice evaluation can either be a single incident or evidence of a clinical practice trend on the ongoing professional performance evaluation and are identified by the appropriate QA&I reviewing committee. A trigger for a focused evaluation may include, but not be limited to:
 - (1) Certain low volume procedures
 - (2) Sentinel or other egregious event,
 - (3) Complaint or event report,
 - (4) Significant variance from accepted standards of clinical practice,
 - (5) Significant variance from comparative peer performance data, and
 - (6) Identified trends or variations.
- d) Criteria are developed that determine the type of monitoring to be conducted which may include chart review, direct observation, monitoring of diagnostic and treatment techniques and discussion with other individuals such as consulting physicians or nursing; duration of performance monitoring and the measures to be employed to resolve any performance issues identified.
- e) Relevant information obtained from the focused professional practice evaluation is integrated into performance improvement activities as needed while preserving confidentiality afforded by applicable laws.

QUALITY RATING LEVELS:

- LEVEL SY/EDU: System issue or educational opportunity identified not specific to provider.
- Issue or educational opportunity referred to appropriate department for action, if needed
- LEVEL 0: No evidence of quality of care issue.
- No action required
- LEVEL 1: Minor quality management concern (process/documentation) with no adverse effect on the patient.
- No action required
 - Educational letter, if needed
- LEVEL 2: Quality management concern/documentation deficiency with the potential for significant adverse effects on the patient.
- Action plan, if needed
- LEVEL 3: Quality management concern/documentation deficiency with significant adverse effects on the patient.
- Action plan required
- LEVEL 4: Quality management concern resulting in death of the patient.

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- Performance of Root Cause Analysis required

Disruptive Behavior: Any abusive conduct, sexual or other forms of harassment, or any verbal or physical behavior that harms or intimidates others to the extent that safety or quality within the healthcare environment is compromised.

III. Responsibilities/Procedures

A. OPPE Review Process

1. Rule and rate based indicators:

- a) Each Medical Staff QA&I Committee identifies relevant rule and rate based indicators for its department and/or divisions. Indicators are approved by the Medical Staff.
- b) Predetermined thresholds for each indicator are identified as appropriate.
- c) When a threshold is exceeded/ variance identified, the QA&I Committee will gather and review additional information in order to:
 - (1) Identify if there are patterns or trends,
 - (2) Determine if there is relationship to other performance criteria,
 - (3) Determine if an outlier exists, and
 - (4) Determine if variance is acceptable.
- d) Recommendations from the department chair include, but are not limited to:
 - (1) No further action,
 - (2) Need for additional information,
 - (3) Focused professional practice evaluation,
 - (4) Revise/limit current existing privileges,
 - (5) Discontinue existing privileges.
- e) Rule and rate based indicators are evaluated periodically to determine if the indicator(s) and threshold(s) should be modified.

2. Individual case reviews:

- a) Cases for individual case review will be based on Medical Staff occurrence screens specific to the department and may include:
 - (1) Event Report Forms
 - (2) Re-admissions
 - (3) Mortality Lists
 - (4) Autopsy Reviews
 - (5) Transfers to other Facilities (Hospitals)
 - (6) Unplanned Admission after outpatient procedure
 - (7) Event/Complication
 - (8) Low Apgar
 - (9) Referral/Complaint
- b) Individual case review can also be performed when a threshold for a rule or rate based indicator is exceeded.

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3. The Quality and Risk Management department's Nurse Reviewer reviews all indicators and cases in advance and brings them to committee for individual case review. Committee meetings occur as outlined in the Medical Staff Department Rules and Regulations. Ongoing OPPE data will be presented biannually to the appropriate QA&I Committee for review and action.
4. If the committee does not wish to review every individual case in detail, the QA&I Chairman, or designee, may identify cases that need to be reviewed by committee.
5. Each individual case for review will be assigned to an appropriate QA&I Committee member for presentation to the committee. Whenever possible, relevant materials will be made available to committee members prior to the meeting.
6. The reviewer will report the reason for the referral and review the medical record. The reviewer may recommend that further information be obtained before further committee review.
7. The reviewer will present the case to the committee and, if applicable, the attending physician(s) involved in the case may provide additional information before being excused.
8. If the physician or practitioner did not attend the meeting and further information is needed, the physician or practitioner will be asked to respond in writing, or in person, at the next QA&I Committee meeting.
9. QA&I Committee rates each case.
10. The physicians or practitioners are notified in writing of the outcome.
11. If a practitioner disagrees with any finding of the QA&I Committee, he or she may submit written comments that will be filed with the committee's findings.
12. If corrective action is recommended by the QA&I Committee and the practitioner disagrees, the case may be referred for external review.
13. If one QA&I Committee member disagrees with the decision of another member on an issue which is of concern to both, that issue may be referred for external review.
14. Care provided by resident physicians will be attributed to the attending/supervising physician during the evaluation and rating process. However, concerns about residents performance issues will be referred to the Graduate Medical Education (GME) office, as will any process issues relating to resident supervision. The GME office will be asked to provide feedback to the QA&I Committee as to the results of any such referrals.
15. Decisions of the QA&I Committee will be determined by simple majority vote.

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16. Participation by the practitioner under review in the professional practice evaluation (PPE) process.
 - a) The practitioner under review is provided with a written letter detailing the PPE outcome and the reviewer's comments. The practitioner under review is afforded the opportunity to respond to the Medical Staff QA&I Committee with any questions or additional information they may have regarding the case. The determination remains final if the QA&I Committee has not received a written response from the practitioner under review within sixty (60) days from the date of the Professional Practice Evaluation Case Review letter.
17. OPPE is conducted continuously and reported to the appropriate QA&I Committee for review and action biannually.
18. If the committee does not wish to review each ongoing evaluation report biannually, the Chairman, or designee, and Nurse Reviewer may separate the cases into those that require trending and those that require review by the committee. A summary of the trend cases will be presented to the committee and members have the option to request full review of any case.
19. All recommended coaching, education, or other corrective measures will be conveyed to the practitioner by the Department Chairman and will be tracked by the Quality and Risk Management department with results reported to the QA&I Committee.
20. If an OPPE review results in the recommendation for a FPPE or a revision, limitation or discontinuation of privileges, the recommendation will be forwarded to MEC for ratification. The practitioner shall be afforded the rights to an appeals process as outlined in Article VII of the Medical Staff Bylaws.
21. Letters noting evaluation of biannual ongoing professional practice evaluation will be sent to physicians and practitioners.

B. FPPE Review Process

1. Indications:
 - a) All new practitioners.
 - b) All new privileges for existing practitioners.
 - c) All practitioners returning from a leave of absence of greater than one year and a leave of absence less than one year upon recommendation of department chairman or department member with MEC approval.
 - d) Any single egregious case or sentinel event as determined by the relevant QA&I Committee, or Department Chairman, may be referred for consideration of FPPE.
 - e) When indicator thresholds are exceeded within the agreed upon time.
 - (1) A rate or rule based indicator exceeds a predetermined threshold defined by the appropriate QA&I Committee or MEC.
 - (2) These indicators do not result in automatic referral to MEC for consideration of FPPE. The relevant QA&I Committee will consider whether referral is indicated based on the individual circumstances.

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- f) Upon referral, the MEC will determine whether FPPE is warranted.
- 2. The FPPE process will be essentially parallel to the OPPE process, with the following exceptions:
 - a) Any FPPE (with the exception of routine proctoring) will be performed by the QA&I Committee.
 - b) Review is not restricted to individual cases, rates and rules, but may extend to all areas of practice, as determined by the QA&I Committee.
 - c) The QA&I Committee, in conjunction with the involved practitioner, will develop a performance monitoring plan. The plan will include:
 - (1) What is to be monitored (outcomes, complications, technique, etc.),
 - (2) Method of evaluation (direct observation, proctoring, chart review, comparative quality data, etc.),
 - (3) Duration of the evaluation (# of procedures, # of admissions, length of time, etc.),
 - (4) Internal or external review (see J. Circumstances requiring external professional practice evaluation).
 - d) The QA&I Committee will complete their review of facts and will forward a report to the Department Chairman in a timely fashion, but in no event later than 30 days after the performance monitoring has been completed. The Department Chairman will formulate the recommendation(s).
 - e) The Department Chairman will notify the involved practitioner of the findings and recommendation(s). In most situations, the practitioner will have the opportunity to respond before any recommendations are acted upon.
 - f) The Department Chairman will forward the report and recommendation(s) to the Medical Executive Committee for ratification. Recommendations may include, but are not limited to:
 - (1) Education and/or counseling,
 - (2) Proctoring,
 - (3) Additional monitoring/evaluation,
 - (4) System issue referral,
 - (5) Corrective action as defined by Article VII Interviews, Hearings and Appellate Review of the Medical Staff Bylaws.
 - g) The MEC will receive regular summaries of such focused reviews, including major findings, conclusions, recommendations and required actions, at least annually.
- C. Circumstances under which External Peer Review may be requested:
 - 1. Lack of internal expertise in the clinical procedure or area under review.
 - 2. When only one physician in a specialty is on medical staff, the case will be reviewed within the expertise of the department or may be referred to an external organization.
 - 3. If requested by the Medical Staff President, Medical Staff Department Chairman, Vice President of Medical Affairs, MEC or the Board.
- D. Disruptive Behavior Review Process

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1. Refer to Medical Staff Code of Conduct MA-05 for details.
 - 2.
- E. Reliability and Consistency of the Review Process
1. Professional practice evaluation will be conducted in a manner that is objective, equitable, and consistent.
 - a) Case selection will be done by use of pre-selected indicators and also in quality plans for each department.
 - b) Review of cases will be performed by committee in accordance with procedures outlined in this document.
 - c) The MEC will monitor reliability and consistency of each Medical Staff QA&I Committee based on quarterly activity reports submitted to MEC.
- F. Participants in the Review Process
1. Composition, meeting frequency and quorums are outlined in each medical staff department rules and regulations.
 2. Quality and Risk Management's Nurse Reviewer is assigned to support each Medical Staff QA&I Committee and will attend all meetings and assist with facilitating the committee's work. This individual prepares data and coordinates follow up monitoring.
- G. Medical Staff Professional Practice Evaluation (PPE)
1. The PPE will be conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed as quickly as possible and within 120 days from the date of referral.
 2. Complex cases may require additional review time beyond 120 days. It may be one where multiple services are involved, or one which requires external review/
 3. An FPPE may also take longer to complete, but the involved practitioner should be kept well informed as to the proceedings.
- H. Oversight and reporting
1. Direct oversight of the professional practice evaluation process is delegated by the MEC to the Medical Staff QA&I Committees.
 2. The MEC will meet regularly to review the findings of the QA&I Committees as well as quality plans from each department chairman.
 3. QA&I Committees will report to the MEC at least quarterly.
- I. Circumstances requiring external professional practice evaluation
1. External PPE may take place under the following circumstances when deemed appropriate by the QA&I Committee.
 - a) Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees, when conclusions from this review will directly affect a practitioner's privileges.
 - b) Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty or specific issues under review or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review.
 - c) Other – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for

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quality monitoring. In addition, the QA&I Committee, MEC or Vice President of Medical Affairs may obtain external professional practice evaluation in any circumstances deemed appropriate.

- J. Conflict of interest
 - 1. A member of the medical staff asked to perform professional practice evaluation has a conflict of interest if, for example, he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the physician involved as direct competitor or partner.
 - 2. It is the individual reviewer's obligation to disclose any potential conflict to the QA&I Committee.
 - 3. If approved by the QA&I Committee, individuals determined to have a conflict may be present during the group discussion and professional practice evaluation, provided the group is made aware beforehand of the conflict. They will, however, be required to recuse themselves from voting on the rating of the case.
 - 4. Any disputes regarding conflicts of interest will be resolved by the initial QA&I Committee, subject to review by the Vice President of Medical Affairs.

IV. Special Considerations

A. Confidentiality

- 1. Professional practice evaluation information is privileged and confidential in accordance with Medical Staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
 - a. The hospital will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in secure locations. Provider specific professional practice evaluation information includes information related to:
 - i. Performance data for all dimensions of performance measured for that individual physician..
 - ii. The individual physician's role in sentinel events, significant incidents, or near misses.
 - iii. Correspondence to the physician regarding recommendations, comments regarding practice performance, or corrective action.
 - iv. Reports and correspondence regarding alleged disruptive behavior.
 - b. Professional practice evaluation information is available only to authorized individuals who have a legitimate need for this information based upon their quality improvement responsibilities as a Medical Staff leader or hospital employee. Individuals shall have access to the information only to the extent necessary to carry out their assigned responsibilities.
 - c. On request, any practitioner may review his or her own quality data. Practitioners

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may provide a written response to anything in their quality file, and this response will be kept with the other quality information.

- d. No copies of professional practice evaluation documents will be created and distributed unless authorized.

V. References

Medical Staff Bylaws
Medical Staff Rules and Regulations
Medical Staff Code of Conduct MA-05
Administrative Policy HR-17 Sexual Harassment
GSHS Code of Conduct, Standards for Service Excellence
Administrative Policy HR-63 Workplace Behavior & Conduct

VI. Attachments

VII. Applicable Standards/Regulations

The Joint Commission Medical Staff standards
Pennsylvania Peer Review Protection Act
Medical Care Availability and Reduction of Error Act of 2002 (Act 13 or MCare Act)

VIII. Responsible Party

Risk Manager/Patient Safety Officer

IX. Collaboration Teams

Vice President of Medical Affairs
Manager, Quality and Performance Improvement

X. Approval Groups

Medical Executive Committee
Joint Conference of the Board
PPRC

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