HOLY CROSS GERMANTOWN HOSPITAL MEDICAL STAFF PERFORMANCE ASSESSMENT PLAN

Purpose

The Medical Staff Performance Assessment Plan is designed to promote and maintain high standards of patient care by providing ongoing monitoring and evaluation of the professional performance of the Medical Staff of Holy Cross Germantown Hospital. The plan outlines the Peer Review, the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE) process.

Results of practitioner-specific data from Peer Review, OPPE, and FPPE will be reviewed and considered by each Department Chair and the Credentials Committee in making practitioner-specific credentialing and privileging decisions.

Aggregate data will also be used in hospital-wide performance improvement activities. Specific recommendations for process improvements or trends that indicate a need for process review will be forwarded to the hospital Quality Improvement Council for consideration.

Responsibility

In accordance with the Medical Staff Bylaws, the Medical Executive Committee (MEC) is accountable to the Board of Trustees for the ongoing monitoring and evaluation of the quality of care and professional performance of the Medical Staff of Holy Cross Germantown Hospital. It is the responsibility of the MEC to oversee this Medical Staff Performance Assessment Plan.

The MEC delegates to the Chair of each department the responsibility for ongoing implementation of this plan. This includes: 1) identifying objective criteria to determine which cases will require individual case review (peer review); 2) overseeing individual case review process; 3) evaluating the Department and its members through a semi-annual review of aggregate and individual-specific data (OPPE); 4) identifying individual-specific rate-based indicators for OPPE; 5) determining the process, plan, and criteria for evaluation of new privileges (privileging FPPE); and 5) conducting an evaluation when a question arises regarding a practitioner's ability to provide safe, high-quality patient care within the scope of previously granted privileges (administrative FPPE).

Each Department Supervisory Committee may appoint one or more Department Review Committees and a Chair to oversee its activity. The Department Review Committee is comprised of Department members (including appropriate sub-specialists) whose responsibility includes performing individual case reviews and, based on those reviews, making recommendations to the Department Supervisory Committee. The Supervisory Committee in whole or in part may serve as the Review Committee.

Confidentiality

All information, reports, data or other materials utilized in the course of medical staff performance assessment activities are undertaken to improve the quality of care, or as part of a review generated as result of this plan, are afforded the protections under Maryland law granted to a Medical Review Committee (see Annotated Code of Maryland, Health Occupations, Section 14-501). As such, all information, reports, data, minutes or other documents are privileged, confidential and not discoverable.

The following statement is required to be affixed to documents or forms that are designated as quality improvement documents:

PEER REVIEW OF INDIVIDUAL CASES

The process of peer review involves an evaluation of the professional performance of physicians, physicians' assistants, nurse practitioners, podiatrists, dentists and other credentialed professionals who are privileged to provide clinical services at Holy Cross Germantown Hospital. All such credentialed individuals are hereafter referred to as practitioners. Peer review is performed by other professionals who have a similar clinical practice and are able to evaluate performance in consideration of the training and scope of practice of the reviewed practitioner.

Criteria for Review – Each Department Chair or Supervisory Committee will select criteria to use in determining the types of cases that always require individual case review. These "automatic" reviews do not presume that the occurrence alone is evidence of error or professional misjudgment. Examples include death of a full term neonate and return to the OR within 24 hours. Review criteria should be re-assessed every two years.

1. Identification and Referral of Cases – In addition to the established criteria for review, cases may be identified by many sources including, but not limited to concurrent review of medical records by HCH staff or members of the Medical Staff, hospital event reports, patient complaints, or referrals from committees and/or other departments. Cases identified as meeting the criteria for individual case review should be forwarded to the hospital's Performance Improvement (PI) Department for referral to the appropriate Department Review Committee.

2. Issues that are purely behavioral or compliance in nature will be referred directly to the Department Chair for resolution by the Chair or Supervisory Committee, as the Chair deems appropriate. Behavioral issues (e.g., inappropriate language or physical actions) or compliance issues (e.g., failure to respond or provide clinical coverage) are not addressed as part of the protected peer review process.

3. Individual Case Reviews – Cases identified as requiring peer review will be evaluated by the appropriate Department Review Committee in whole or by an individual practitioner reviewer serving as a member of the Review Committee. No practitioner may review his or her own case. Conflicts of interest, e.g., personal, financial, or professional relationship to the practitioner being reviewed or personal involvement in the case must be disclosed. The Review Committee Chair will decide whether such conflict precludes an impartial review.

4. Circumstances Requiring External Peer Review –Peer review by an external peer practitioner may be recommended if any of the following criteria are met: 1) the practitioner or event being reviewed involves medical expertise beyond that possessed by other members of the Medical Staff (e.g., only one

or two practitioners on the Medical Staff are expert in the particular field being reviewed); or 2) the practitioner or event being reviewed cannot be accomplished in an objective and impartial manner due to conflict of interest; or 3) the Department Chair and/or the President of the Medical Staff, and/or the Chief Medical Officer determines that it is in the best interest of the Department, the Medical Staff, the practitioner, or the Hospital to have the matter reviewed by an external practitioner. External reviews must be approved by the Chief Medical Officer.

5. Timeliness of Review – When a case meets criteria for peer case review, the case is referred to the Performance Improvement (PI) Department. PI enters the case in Midas with a referral date of the next available committee meeting. Cases should be addressed by the Department Review Committee within 45 days of the referral date. The President of the Medical Staff or the Chairman of the Department may request an expedited case review. If an expedited case review is requested, PI will notify the Department Review Chairman and the case is added to the current case review assignment list. With the exception of cases that require referral for external peer review, cases should be reviewed and either closed or referred to the Department Supervisory Committee within 120 days of referral to the PI Department. Responsibilities of PI, the Medical Staff Office, the Chair and Review Committee member are outlined in Attachment 1.

6. General Review Process – Referred cases will be reviewed by a designated committee/practitioner reviewer according to the following process.

    1. The assigned practitioner reviewer will examine the medical record and any other available documentation, evaluate the care provided, and document a conclusion and the rationale for that conclusion on a Clinical Review Form (Attachment 2). The conclusion of the review includes assigning a Severity Level (SL) for each case.
       Severity Levels
       SL-0: No occurrence: case referred in error
       SL-1: No quality of care issues identified: No action required
       SL-2: Process issue identified or performance issue of personnel other than practitioner identified
       SL-3: Practitioner management issue identified; minor variation from accepted practice
       SL-4: Practitioner management issue identified; significant variation from accepted practice with opportunity for improvement
       SL-5: Practitioner management issue identified; practitioner management determined to be unacceptable and action plan required

    2. If the decisions or actions of a practitioner in another Department are questioned by the Review Committee (SL-2), the case should be referred to that other Department's Review Committee.

    3. If performance of a non-credentialed individual (e.g. nurse, technician, or pharmacist) is questioned by the Review Committee (SL-2), the case should be referred to the appropriate hospital supervisor. The hospital supports an analogous the peer review process for nursing and other non-credentialed healthcare professionals.

    4. If a hospital process issue is identified during the case review (SL-2), the concern should be referred to the hospital Quality Improvement Council for further evaluation and action as required.

    7. If the actions or decisions of the practitioner being reviewed are assigned SL-4 or SL-5, a certified letter will be sent to the practitioner's home address. The letter will identify the specific concerns

and request any additional relevant information. A response is requested within fourteen (14) days. If there is no response within that period, a second letter will be sent notifying the practitioner that s/he has seven (7) days to respond. The practitioner's response will be reviewed at the next Review Committee meeting.

8. If the practitioner fails to respond within the allowable time frame, the case will be closed by the Review Committee with a recommended Severity Level (SL- 4 or SL-5) and notation of the failure to respond. The case is forwarded to the Supervisory Committee for final severity level assignment and any necessary actions.

9. After considering the practitioner's response, if the Review Committee affirms that the practitioner's management of the case represents a significant variation from accepted practice (SL-4 or SL-5), the case will be referred to the Supervisory Committee. The Supervisory Committee will afford the practitioner a time-limited opportunity to provide any additional information and/or explanations prior to decision. The practitioner may address the Supervisory Committee in writing or in person.

10. After review of the practitioner's response, if the Review Committee determines that the practitioner's management of the case was appropriate (no longer considered SL-4 or SL-5), the practitioner will be notified by letter of the committee findings and the case will be closed.

11. If the Review Committee identifies a minor variation from accepted practice (SL-3), the practitioner will be notified by letter of the committee findings and the case will be closed.

12. Following review of a case rated SL-4 or SL-5, the Supervisory Committee will notify the practitioner in writing of its findings and any recommended actions. The actions may include a requirement for individual education or training, department wide communication on lessons learned (without provider or patient specifics), or modification of standard procedures.

13. Required Documentation – For each case reviewed, conclusions and recommendations (if applicable) must be documented by the committee/reviewing practitioner, signed and dated (Attachment 2). Regardless of the decision reached, the conclusion should be supported by a rationale that specifically addresses the issue for which the case was referred.

14. At least annually, the MEC will review of the aggregate peer review Severity Level numbers by department, the timeliness of response by practitioners, case summary for cases closed with an SL-4 or SL-5 (with any corrective actions), and a summary of systems issues identified as part of the peer review process.

Peer Review Education

Physicians, Nurse Practitioners, and Physician Assistants who participate on Department Review Committees and/or Supervisory Committees will be oriented by Department Chair or PI staff to a general understanding of the peer review process, responsibilities and protections. General information on peer review and quality improvement processes will be included in initial orientation for hospital employees and practitioners. Education will include, as applicable to individuals; the process for reporting incidents and referring cases for peer review, peer review referral criteria for the practitioner's Department, responsibilities of peer review participants, and protections for practitioners under review and for those reviewing cases.

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

OPPE is the ongoing monitoring of practitioners and providers to assess the quality of care delivered and to ensure patient safety. The results of a semi-annual review by the Department Chairman and any recommended actions will be documented in the minutes of the Supervisory Committee and are subject to review by the Medical Executive Committee. OPPE may be supported by data from coded records (Advisory Board Crimson Clinical Advantage), by the results of concurrent practitioner review or by summative observational qualitative assessment.

OPPE Review Process Steps Using Crimson (Attachment 3)

1. The PI Department will be responsible for preparing individual practitioner OPPE profile reports via the Crimson Clinical Advantage database twice each year. Attribution to individual practitioners will include their role as attending, performing and consultant as defined in Crimson based on coded medical records. Crimson comparisons are "risk adjusted" for individuals using APR-DRGs and the comparison population for statistical comparisons is to aggregate hospital performance over the last 27 months.

2. The data elements in the OPPE review may include:
    - Case Volume and Length of Stay (LOS)
    - Readmission rates
    - Case Mix and Case Mix Index
    - Average Severity Level and Mortality
    - Complications of care
    - Primary caesarean section rate
    - SCIP Measures and other Core Measure results
    - Medical Records compliance
    - Peer Review results
    - Complaints and Compliments
    - Patient satisfaction results (HCAHPS)

3. Each Department Chair will identify critical OPPE metrics in two categories: 1) measures with sufficient volume for individuals to make valid statistical statements about variation (e.g., LOS); 2) high impact areas were singular events (e.g. Core Measures fallouts and HAC events) warrant notice.

4. The PI Department will review of the profiles screening for outliers in critical metrics or other concerning patterns.
    a. The pre—reviewer will review to determine if any indicators in a profile are flagged as greater than 1 SD from the comparative system mean.
    b. If the profile is within 1 SD of the comparative mean, the pre-reviewer will flag the profile as "profile acceptable".
    c. If the profile falls outside 1 SD of the comparative mean, the profile will be flagged by the pre-reviewer as "profile will need follow-up"

5. The steps in the follow up by the Department Chair include:

    a. Review of any profile that requires follow up

b. Review and discussion with the practitioner on cases requiring follow up

c. Documentation on profiles requiring follow up

d. Electronic signature and storage of profile results in Crimson

OPPE by Concurrent Review

The Department of Imaging OPPE is based on standardized random over read of medical images. The Department of Pathology conducts routine over reads of surgical pathology and concordance of frozen and final diagnoses for surgical pathology. Significant disagreements are reviewed and any required actions are documented in the departmental quality minutes. Both departments' results are reported, in aggregate, to the Quality Improvement Council.

OPPE by Summative Review

Attribution of outcomes to individual practitioners is problematic when care is delivered by closely integrated group practice over a prolonged course of care. This includes neonatology practice, intensive care, and many consultative specialists. In those cases, OPPE may consist of the Department Chair providing a summative assessment of acceptability or concern based upon direct observation, review of shared cases, peer review results and patient concerns.

Evaluation of Nurse Practitioners (NP) and Physician Assistants (PA) is not supported by Crimson as they are rarely identified as attributable practitioners in any capacity. The care that they provide is subject to concurrent oversight or knowledge by a number of other practitioners. OPPE of NPs and PAs is a summative assessment of acceptability or concern based upon direct observation and review of shared cases by supervising practitioners (Attachment 4).

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Focused professional practice evaluation (FPPE) refers to an evaluation of privilege-specific competence of a practitioner. A privileging FPPE (pFPPE) is performed when a practitioner does not have documented evidence of competently performing a requested privilege. This is most often part of an initial credentialing and privileging process but also includes a request for expansion of privileges for a previously credentialed practitioner. An administrative FPPE (aFPPE) may be conducted when a question arises regarding a practitioner's ability to provide safe, high-quality patient care within the scope of previously granted privileges. The MEC has ultimate oversight of both the pFPPE and the aFPPE processes.

Privileging FPPE (pFPPE)

The Department Chair is responsible for designing the pFPPE plan, assigning privileged medical staff members to monitor performance, for reviewing the data collected, and for making recommendations to the Credentials Committee for appointment and the scope of privileges for each applicant. The pFPPE plan is designed to be consistent for applicants with similar training and experience. An individual practitioner's pFPPE is monitored by the Credentials Committee in collaboration with Department Chair (or Subsection Chair).

Privileging FPPE (pFPPE) Plan Development

Department Chairs should consider the following six general categories as a framework for developing the FPPE plan.

- Patient Care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems- based practice
- Outcomes data

The pFPPE plan should be customized/tier based on the following factors:

- Individual's training and experience
- Practitioners from outside residency programs (unknown data)
- Practitioners directly from residency programs practicing at Holy Cross Germantown Hospital (known data)
- Practitioners with documented record of performance of privilege and associated outcomes versus those with no record (limited known data)
- Previous plans for practitioners in the specialty
- Guidelines from professional societies or regulatory bodies
- The scope of requested privileges.

The pFPPE plan will include

- Area of focused monitoring
- Monitoring time frame
- Volume or number of cases to be monitored (percentage of cases, number of cases per month, all cases)
- Method (s) of monitoring (prospective, concurrent, or retrospective)

- Outcomes measures that will be used in the plan

Privileging FPPE (pFPPE)- Responsibilities of Department members:

Department members are assigned to evaluate the applicant. The role is that of an evaluator—to review and/or observe cases—not of a supervisor or consultant. The practitioner who is serving solely in this monitoring function is indemnified in accordance with medical staff bylaws. Evaluators must be members in good standing of the medical staff of Holy Cross Germantown Hospital and must practice in the same or related specialty as the requesting practitioner. All members of the active medical staff have a responsibility to serve as FPPE evaluators when asked to do so. Repeated refusal to accept assignment or to fulfill FPPE obligations will be referred to the Department Supervisory Committee.

As required by the pFPPE plan, evaluators will observe the procedure being performed, monitor management of admissions, or review the completed medical record following discharge and complete evaluation forms. Attachments 5, 6, 7 and 8 are examples of pFPPE evaluation forms. Other tools may be developed by departments based on their practice needs and available information. The evaluator will ensure the confidentiality of the monitoring results and forms and will submit a summary report at the conclusion of the monitoring period.

If during the pFPPE process the medical staff leadership is notified of concerns about the pFPPE practitioner's competence to perform specific clinical privileges or about the care of a specific patient, the Department Chair will review the relevant medical records and either continue or modify the pFPPE plan or refer to the Departmental Review or Supervisory Committee for actions in accordance with medical staff bylaws.

Responsibilities of the practitioner undergoing pFPPE:

The clinical experience of a practitioner at another hospital may be considered when establishing a FPPE plan. The practitioner is responsible for identifying the hospital where information may be obtained and for to ensuring that representatives of the hospital provide the requested information.

In accordance with the monitoring plan, the practitioner will notify the evaluator(s) of cases in which care is to be evaluated prospectively or concurrently. For elective surgical or invasive procedures where observation is required, the practitioner must secure agreement from an evaluator to attend the procedure. The practitioner will provide the evaluator with necessary information not available in the electronic medical record about the patient's clinical history; pertinent physical findings, lab, and x-ray results; the planned course of treatment or management.

The pFPPE practitioner will have the prerogative of requesting a change of evaluator from the Department Chair if a disagreement adversely affects his or her ability to complete the monitoring plan timely and satisfactorily. The Department Chair will make recommendations to the Credentials Committee for final action.

The pFPPE practitioner will inform the Department Chair of major complications associated with the privileges being monitored as part of pFPPE. This includes cases that will be referred to peer review based on Departmental criteria for the requested privileges. The practitioner will complete his/her portion of monitoring forms and the summary report.

Privileging FPPE (pFPPE) -Duration of monitoring period:

The initial duration for pFPPE monitoring will be established by the Credentials Committee. Monitoring begins with the practitioner's first admissions or performance of the newly requested privilege. Monitoring may be for a specific period of time or for a specific number of cases. The monitoring period may be extended by the Credentials Committee if initial concerns are raised that require further evaluation or if there is insufficient activity during the initial period. The total monitoring period may not exceed 12 months.

If the practitioner fails to complete the monitoring requirements by the expiration of the pFPPE monitoring period, the additional or new privileges that are the subject of monitoring will be deemed to have been voluntarily relinquished by the practitioner. The practitioner will immediately stop exercising said privileges. Privileges relinquished as a result of an incomplete pFPPE are not considered an adverse privileging action and will not be reported to regulatory agencies. The practitioner will not be entitled to a hearing or other procedural rights as set forth in the medical staff bylaws or the fair hearing and appeal policy for any privilege that is voluntarily relinquished due to an incomplete, expired pFPPE. The practitioner may reapply for privileges and is subject to a new pFPPE process.

Privileging FPPE (pFPPE) -Responsibilities of the Medical Staff Office (MSO):

The MSO will send a letter at the start of the monitoring period to the pFPPE practitioner and to the assigned evaluator(s) containing:

- a copy of the privilege request form;
- the names, addresses, e-mails, and telephone numbers of both the requesting practitioner and the evaluator(s);
- a copy of this policy;
- a copy of the approved monitoring plan; and
- Forms to be completed by the practitioner and evaluator(s).

As required by individual monitoring plans, the MSO will develop a mechanism for tracking required admissions or procedures performed by the practitioner being monitored. The MSO will contact the pFPPE practitioner and evaluator(s) if required reports are not received. The MSO will submit a report to the MEC of monitoring activity for all practitioners in pFPPE each quarter.

Administrative FPPE (aFPPE)

An administrative FPPE (aFPPE) may be conducted when a question arises regarding a practitioner's ability to provide safe, high-quality patient care within the scope of previously granted privileges. Based on input from individual practitioners, staff, practitioner specific trended data including OPPE data, concerns raised by individual case reviews, or based upon executive concerns from the Department Supervisory Committee, President of the Medical Staff, Hospital President, Chief Medical Officer or Chief Quality Officer an aFPPE may be initiated The results of such an administrative FPPE may be used in the credentialing process or to initiate an involuntary modification or loss of privileges. Such adverse actions are reportable to the National Practitioner Data Bank and the State Board of Medicine and are subject to hearing and appeal in accordance with Medical Staff bylaws.

The Department Chair is responsible for designing the aFPPE plan, assigning privileged medical staff members to monitor performance, reviewing the data collected, and making recommendations to the MEC based on consultation with Medical Staff leadership and the CMO concerning privileges for the individual practitioner.

In developing an aFPPE plan, consideration should be given to:

- Identification of areas of concern

- Defining the monitoring approach (e.g. case selection: prospective, concurrent or retrospective case review) record review, direct observation
- Type of assessment (e.g. qualitative or quantitative)
- Volume or number of cases to be monitored (percentage of cases, number of cases per month, all cases
- Monitoring time frame and duration
- Outcomes measures that will be used in the plan
- Comparative peer data and prior evaluations
- Applicable professional standards

If during the aFPPE process the medical staff leadership is notified of concerns about the practitioner's competence to perform specific clinical privileges or about the care of a specific patient, the Department Chair will review the relevant medical record(s) and either continue or modify the aFFPE plan or refer to the Departmental Review or Supervisory Committee for actions in accordance with medical staff bylaws.

Administrative FPPE (aFPPE) -Responsibilities of Department members

Department members are assigned to evaluate the practitioner under review. The role is that of an evaluator—to review and/or observe cases—not of a supervisor or consultant. The practitioner who is serving solely in this monitoring function is indemnified in accordance with medical staff bylaws. Evaluators must be members in good standing of the medical staff of Holy Cross Germantown Hospital, must practice in the same or related specialty as the requesting practitioner, and must have unrestricted privileges to perform any specific procedure(s) to be monitored. As required by the aFPPE plan, evaluators will observe the procedure being performed, monitor management of admissions, or review the completed medical record following discharge and complete evaluation forms.

The evaluator will ensure the confidentiality of the monitoring results and forms and will submit a summary report at the conclusion of the monitoring period. If, at any time during the monitoring period, there are concerns about the practitioner's competence to perform specific clinical privileges or to provide care appropriate for his/her specialty, the evaluator will promptly notify the Department Chair.

All members of the active medical staff have a responsibility to serve as FPPE evaluators when asked to do so. Repeated refusal to accept assignment or to fulfill FPPE obligations will be referred to the Department Supervisory Committee.

Administrative FPPE (aFPPE) -Responsibilities of the practitioner undergoing aFPPE:

In accordance with the aFPPE monitoring plan, the practitioner will notify the evaluator(s) of cases in which care is to be evaluated prospectively or concurrently. For elective surgical or invasive procedures where observation is required, the practitioner must secure agreement from an evaluator to attend the procedure. The practitioner will provide the evaluator with necessary information not available in the electronic medical record about the patient's clinical history; pertinent physical findings, lab, and x-ray results; the planned course of treatment or management.

The aFPPE practitioner will have the prerogative of requesting a change of evaluator from the Department Chair if a disagreement adversely affects his or her ability to complete the monitoring plan timely and satisfactorily. The Department Chair will make recommendations to the Credentials Committee for final action.

The aFPPE practitioner will inform the Department Chair of major complications associated with the privileges being monitored as part of aFPPE. This includes cases that will be referred to Peer Review based on Departmental criteria for the requested privileges.

The practitioner will complete his/her portion of monitoring forms and the summary report.

Attachment 1

Monthly TAT schedule	PI	MSO	Committee Member	Committee Chair
Week one	PI runs case list via Midas – cases obtained via reports or via various referral sources	MSO schedules peer review meeting rooms		
	PI delivers hard copies of Midas peer paperwork to MSO			
	PI emails a list of cases for each committee to MSO			
Week two		MSO assigns cases to the Peer Committee member – (except for Perinatal Peer Review– PI makes the assignment)		
		MSO sends all Peer Committee assignments to the members by the end of the second week of the month.		Peer Committee Chairman reviews assignment and case detail as needed.
Week three			Committee members pre-review cases	
Week three – four **Peer meetings are conducted**	PI attends committee meetings, ensures case paper work is complete.	MSO sets up rooms with computers, sign-in sheets, case paper work for each member. MSO provides copies of letters sent and received to committee chairs.	Committee members discuss cases and recommend a SL level. Committee members discuss and assign a final SL.	Peer Committee Chairman oversee meeting, directs discussion, and drafts follow-up letters as needed.
			MD assigned the case completes Midas paperwork.	
Post meeting	PI closes cases and /or entries case updates into Midas.	MSO completes first letter, drafts second letter, contacts chairman for signature, and send letters via register mail with 5 days of receiving the draft letter. If there is no response to the first letter within 14 days of the first letter being sent, MSO sends the second letter.		Peer Committee Chairman drafts required letters and provides the drafts MSO within 5 days of the meeting.
	PI maintains hard copies of completed Midas case review form and copies of letters received from MSO.	MSO emails PI and committee chair when letters are sent.		
		MSO maintains copies of the original letters sent and received, provides copies of letters to PI and for use at the committee meetings.		

Holy Cross Hospital
Confidential Peer Review Information

Service/Committee Name:

QA Case #:

Patient: **DOB:**

Admit Date: **Physician:**

Discharge Date: **Physician Specialty:**

Date of Occurence:

Occurence:

Case Details:

Routing Disposition:

Review Comments:

Conclusions: (check one)

_____0 No occurence identified, case referred in error.

_____1 No quality of care issues identified, no action required.

_____2 Process issue identified, or performance of personnel other than physician questioned.

_____3 Physician management issue identified, minor variation from accepted practice.

_____4 Physician management issue identified, significant variation from accepted practice. *

_____5 Physician management issue identified, physician management determined to be unacceptable. *

Rationale for conclusion: _____

_____

_____

Recommended Action (check all appropriate)

_____1 Letter to physician questioning management.

_____2 * Refer to Supervisory Committee.

_____3 Educ letter/discuss with physician no response required.

_____4 Refer to another department for review/action.

_____5 Provide education for department.

_____6 Refer to MEC and/or QIC for process review.

_____7 Refer to hospital department for review/action.

_____8 Send for outside peer review.

_____9 Defer case.

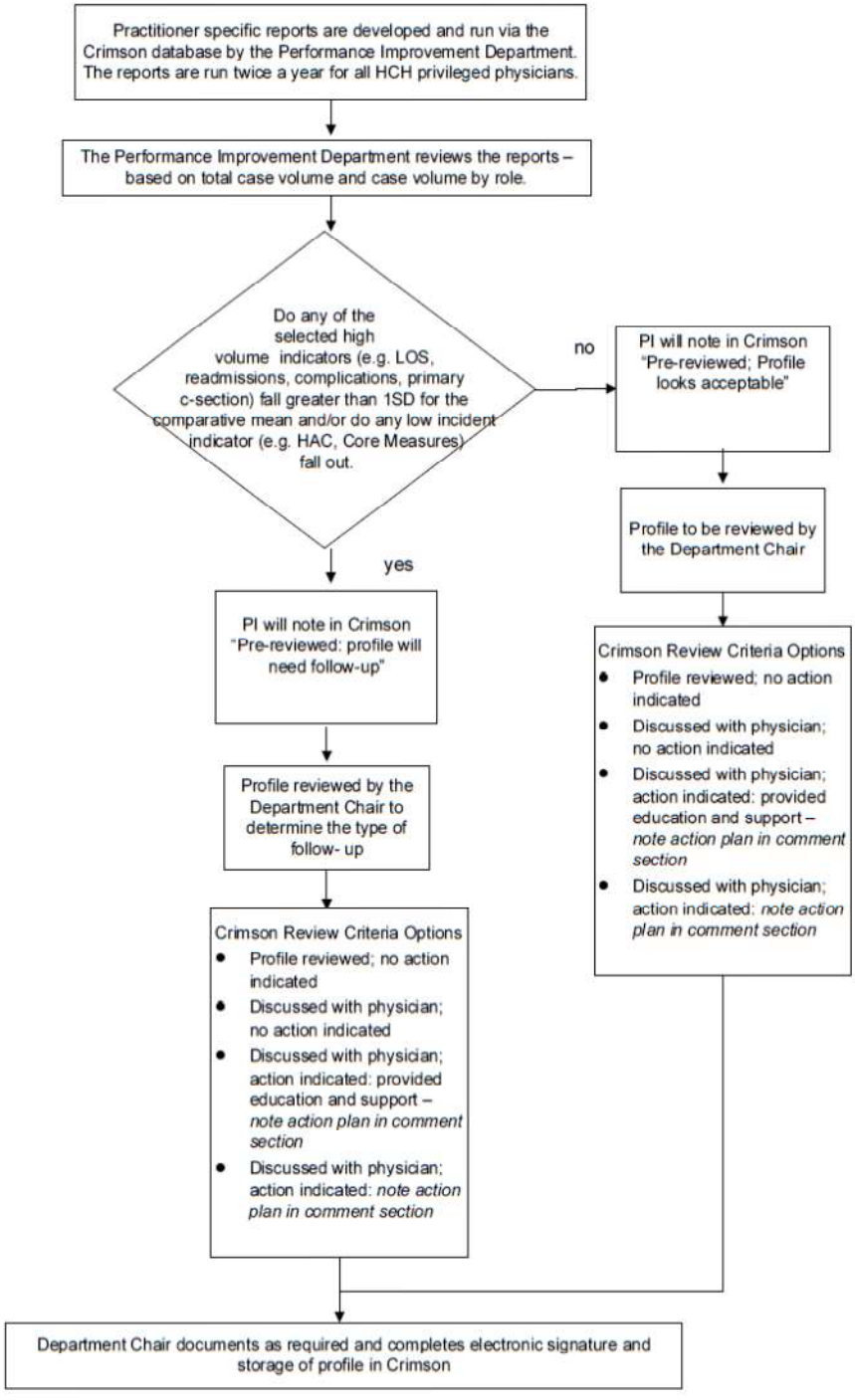
_____CL Closed.

QA PEER BY COMMITTEE

Reviewer's Signature: _____ **Date:** _____

MEDICAL STAFF PERFORMANCE ASSESSMENT PLAN

Ongoing Professional Practice Evaluation (OPPE)



Attachment 4

INDIVIVIDUAL PHYSICIAN, PHYSICIAN ASSISTANT, or NURSE PRACTITIONER for COLLECTIVE PRACTICES

Ongoing Professional Practice Evaluation (OPPE) FORM

Evaluated Practitioner: _____ _____ Group or Department: _____

Evaluation time frame: _____ to _____ Comments are based upon direct observation, review of shared cases, peer review results and patient concerns. Other sources of data or information used:

Evaluator: _____ Evaluator Role/Title_____ Evaluation Date: _____

*** Comments required for assessment categories with unacceptable ratings**

	Acceptable	Not Acceptable	Comments *
Patient Care: Assesses patient clinical status and develops and implements appropriate plan of care			
Directs management of patients in an emergency situation			
Medical Knowledge: Maintains and updates knowledge and skills in specialty area			
Maintains skills in technical procedures (if applicable to specialty) such as: Intubation, Line Placement, Medical Imaging interpretation, and other applicable clinical skills			
Practiced Based Learning: Complies with rules, regulation, bylaws, policies and procedures such as: Infection Control standards			
Attends conferences and in services pertinent to specialty area			
Communication: Communicates with patients, families and clinical staff appropriately			
Professionalism: Maintains the hospital standards related to: Appearance, Adaptability, Attendance, Punctuality, Conduct			
Systems Based Learning: Demonstrates positive relationships with the hospital staff including nurses, mid-level providers, technicians, administrative staff and other member of the health care team			
Demonstrates proficiency in use of hospital computer systems (EMR)			

Attachment 5 Focused Professional Practice Evaluation (FPPE) – Procedural

I. PRACTITIONER INFORMATION

Last Name _____ First Name_____ MD Number_____
Procedure(s) observed: _____

II. PROCTOR: Please rate this practitioner on the six core competencies based upon your direct observation and completion of the Proctoring Documentation Form.

COMPETENCY	Exemplary	Acceptable	Unsatisfactory
Patient Care: ☐ Demonstrates ability to perform all technical aspects of the procedure. ☐ Critically assesses information risks and benefits and makes timely decisions and/or recommendations based on clinical judgment and interaction with nurses and anesthesiologist.			
Medical Knowledge: ☐ Demonstrated knowledge and adherence to established protocols and the application of that knowledge to patient care and the education of others.			
Practice-Based Learning: ☐ Compliance with rules, regulations, and bylaws. ☐ Obtains and documents consents according to policy. ☐ Maintains infection controls standards including sterile preparation, hand hygiene and gowning. ☐ Completes an immediate post operative note. ☐ Conducts a pre-procedure timeout. ☐ Completes a final dictated operative report			
Communication: ☐ Demonstrates interpersonal and communication skills in the OR. ☐ Established and maintain professional relationships with patients, families, and other members of the health care team. ☐ Conducts a debriefing at the end of the procedure.			
Professionalism: ☐ Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients and coworkers.			
Systems-Based Learning: ☐ Demonstrates 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. ☐ Demonstrates the ability the manage OR Team during the procedure. ☐ Demonstrates proficiency in use of hospital computer systems.			

III. PROCTORS ATTESTATION & RECOMMENDATION:

- ☐ **Recommend advancement to ongoing proctoring cycle. I have completed my assessment of the six core competencies, and have reviewed or observed the number of cases indicated on the attached proctoring plan. This practitioner has satisfied all of the requirements of the focused review period.**
- ☐ **Recommend advancement to ongoing proctoring cycle with the following requirements (additional training, CME, monitoring, etc): _____**
- ☐ **Insufficient number of cases available for review at this time. Recommend focused review continue for a period of _____Months**
- ☐ **My findings were unfavorable and I do <u>NOT</u> recommend this practitioner for advancement to the ongoing proctoring cycle. (Attach explanation)**

Proctor Signature: _____ Date: _____

Attachment 6 Focused Professional Practice Evaluation (FPPE) – Non Procedural

I. PRACTITIONER INFORMATION

Last Name _____ First Name_____ MD Number_____

II. PROCTOR: Please rate this practitioner on the six core competencies based upon your direct observation and completion of the Proctoring Documentation Form.

COMPETENCY	Exemplary	Acceptable	Unsatisfactory
Patient Care: Provides 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. Demonstrates ability to manage or appropriately consult on patients with complex medical problems. Critically assesses information, risks and benefits and makes timely decisions and/or recommendations			
Medical Knowledge: Demonstrated knowledge and adherence to established protocols and the application of that knowledge to patient care and the education of others.			
Practice-Based Learning: Compliant with rules, regulations, and bylaws. Maintains established infection control standards including hand hygiene Completes medical documentation according to policy			
Communication: Demonstrates interpersonal and communication skills that enables him/her to establish and maintain professional relationships with patients, families, and other members of the health care team. Responds to pages, updates medical record within established time frame.			
Professionalism: Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients and coworkers.			
Systems-Based Learning: Demonstrates 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. Proficient in use of hospital computer systems.			

III. PROCTORS ATTESTATION & RECOMMENDATION:

- ☐ **Recommend advancement to ongoing proctoring cycle. I have completed my assessment of the six core competencies, and have reviewed or observed the number of cases indicated on the attached proctoring plan. This practitioner has satisfied all of the requirements of the focused review period.**
- ☐ **Recommend advancement to ongoing proctoring cycle with the following requirements (additional training, CME, monitoring, etc): _____**
- ☐ **Insufficient number of cases available for review at this time. Recommend focused review continue for a period of _____Months.**
- ☐ **My findings were unfavorable and I do <u>NOT</u> recommend this practitioner for advancement to the ongoing proctoring cycle. (Attach explanation)**

Proctor Signature: _____ Date: _____

Attachment 7---Physician Surgical Reviewer – Check List

Name of Surgeon Being Reviewed _____ Date of Procedure _____

Name of Procedure _____

The observer/reviewer will shadow the surgeon beginning in the preoperative area and will provide comments on:

Observation	Acceptable	Marginal (Please Explain)	Unacceptable (Please Explain)	Comment
Interactions with the patient/family in obtaining consent before surgery				
Sterile preparation and gowning				
Surgeon leads and/or participates in appropriate time out prior to procedure				
Interaction with nurses and anesthesiologist				
Surgeon's overall management of the team during the procedure				
Surgeon's role in debriefing at the end of the case				
Surgeon's review of the immediate postoperative note				

Signature of Reviewer _____ Date _____

Attachment 8--Physician Medical Record Reviewer – Check List

Physician Being Reviewed Date(s) of Records Reviewed FIN/Medical Record FIN

Type of Record Reviewed and Clinical Issue Addressed (e.g., admission for CHF, consult for elevated creatinine, EGD) The reviewer will access the Electronic medical record and review relevant portions that demonstrate physician critical thinking. This may include history and physician examination, consultation notes, physician orders, progress notes or procedure notes as required. Indicate NA if not applicable to the record review.

Observation	Acceptable	Marginal (Please Explain)	Unacceptable (Please Explain)	Comment
Medical history—including past medical history, family history and social history--is relevant to the clinical issue addressed				
Physical examination is relevant to the clinical issue addressed				
Appropriate informed consent is obtained when required				
Issues of patient decision-making capacity are addressed when appropriate				
The initial evaluation and treatment plan is appropriate and documented to "tell the patient's story"				
Ongoing evaluation and treatment reflects appropriate response to test results (lab, imaging, consults, vital signs) and changes in patients condition				

Signature of Reviewer Date