HACKETTSTOWN REGIONAL MEDICAL CENTER
MEDICAL STAFF POLICY MANUAL

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

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SCOPE

All members of the Hackettstown Regional Medical Center medical and dental staff

PURPOSE

To outline the process by which the hospital, through collaboration with the medical staff, implements Focused Professional Practice Evaluations (FPPEs): A process whereby the organization evaluates the privilege-specific competence of a practitioner. The guidelines outlined here are intended to support an objective, consistent, and systematic process of evaluation for use in the granting, denial, continuation, or renewal of privilege.

DEFINITIONS

Peer: An individual who is practicing in the same profession and who has expertise in the subject matter under evaluation. The level of subject matter expertise required to provide meaningful evaluation of a provider's performance will be based on the area of competency and the nature of the issue or of the data being evaluated.

Proctor: A practitioner who is an agent of the hospital and has the responsibility to assess and report on the competence of another practitioner.

Proctoring: Focused Professional Practice Evaluation (FPPE) of applicants for initial and subsequently requested medical staff privileges. This is a time limited evaluation of the professional's performance in the following areas:

- Patient care
- Medical knowledge
- Practice based learning and improvement
- Interpersonal and communication skills
- Professionalism

Non-Randomized Peer Review: Circumstances in which a review is triggered by a patient complaint, a colleague concern, the case physician's request, an adverse event, an adverse outcome, a regulatory complaint, or an adverse trend for the individual physician.

Randomized Peer Review: Circumstances in which a review is triggered by a non-physician-specific trend or to evaluate presence of evidence-based practice amongst physicians with the same privileges and/or providing similar services.

POLICY

1. A Focused Professional Practice Evaluation is completed for the following circumstances:
   A. Proctoring: The Credentials Committee will have primary oversight of the FPPE done at time of initial appointment to the medical staff. Proctoring period may not be extended beyond one year.
   B. Non-Randomized Peer Review
   C. Randomized Peer Review
2. An external review may be initiated by the Chief Medical Officer in collaboration with the Chair of the Medical Staff PI Committee when appropriate. Circumstances which could initiate an external review include, but are not limited to committee disagreement on case review determination, lack

of case-specific medical expertise or case-specific conflict of interest.

PROCEDURE

1. Proctoring:
   A. The Credentials Committee will determine, based on Department Chair recommendations and approval of the Medical Executive Committee, the practitioner-specific proctoring method(s), number and scope of cases to be proctored and/or reviewed, and the expected time frame for completion of the FPPE.
   Methods may include:
   - Prospective Proctoring [Example: presentation of cases with planned treatment for the proctor's treatment concurrence]
   - Concurrent Proctoring [Example: direct observation of the procedure being performed or medical management through review of history and physical and treatment orders during the patient's hospital stay]
   - Retrospective Evaluation [Example: review of medical records post discharge, interview of personnel involved in the patient's care]

   B. The Department Chair will assign a proctor through support of the Medical Staff Office. The proctor will forward his/her evaluations to the Medical Staff Coordinator as they are completed. Feedback dialogue between the proctor and practitioner should be continuous.
   C. If the proctor determines that the cases are not meeting established standards of care, s/he will take any immediate action necessary to ensure quality and patient safety. S/he will submit a written notification of standard of care concerns or failure to complete the required number of cases within 90 days to the Department Chair, the Chief Medical Officer, and the Credentials Committee Chair for further action.

2. Non-Randomized Peer Review:
   A. The Administrative Director of Quality & Patient Safety is notified of a case which has triggered peer review. S/he completes the 'Background Information' section of the Medical Staff Worksheet [Attachment II] and reviews the medical record to obtain relative facts. S/he provides the Department Chair or designee reviewer with the Medical Staff Worksheet and a verbal summary of the relative facts.
   B. The Department Chair, or designee, reviews the medical record and advises the case physician that the review was triggered and collaborates to obtain relative input. S/he then completes the 'Physician Peer Review' section of the Medical Staff Worksheet and forwards it to the Administrative Director of Quality & Patient Safety.
   C. At meetings of the Medical Staff PI Committee, the Committee Chair facilitates review of a blinded summary of completed Medical Staff Worksheets. The Committee Chair, or designee, completes the 'Medical Staff PI Committee' section of the Medical Staff Worksheet and facilitates follow-through of any identified need for further action.
   D. The Administrative Director of Quality & Patient Safety provides the Medical Staff Coordinator with evaluation outcome data for inclusion in quarterly updated physician dashboards. The data will be expressed as a number and a percentage of all triggered evaluations that were evaluated to reflect no discordance in care.
   1 = Predictable Event, No Discordance in Care 2 = Unpredictable Event, No Discordance in Care
   3 = Slight Discordance in Care 4 = Moderate Discordance in Care

5 = High Discordance in Care

3. Randomized Peer Review:
   A. The Administrative Director of Quality & Patient Safety is notified of circumstances in which randomized peer review is triggered by a non-physician-specific trend or to prospectively evaluate presence of evidence-based practice amongst physicians with the same privileges. S/he collaborates with the referral source and Chief Medical Officer to construct a data collection tool customized to the desired information output. When an initial screening of cases by a non-physician is indicated, the referral source will provide specific, objective screening criteria established by the medical staff.
   B. The Department Chair(s), or designee, reviews the medical record, completes the appropriate section of the data collection tool, and forwards to the Administrative Director of Quality & Patient Safety.
   C. The Administrative Director of Quality & Patient Safety provides the appropriate Department Chair(s) and the Chair of the Medical Staff PI Committee with both aggregate and physician-specific data.
   D. At meetings of the Medical Staff PI Committee, the Committee Chair facilitates review of aggregate data for purposes of practice and process improvement planning. Resulting follow-up actions will be recorded in the committee meeting minutes and acted upon as determined by the committee.
   E. The Administrative Director of Quality & Patient Safety provides the Medical Staff Coordinator with both physician-specific and aggregate evaluation outcome data for inclusion in quarterly updated physician dashboards. The data will be expressed as a number and a percentage of all triggered evaluations that were evaluated to reflect no discordance in care.
      1 = Predictable Event, No Discordance in Care
      2 = Unpredictable Event, No Discordance in Care
      3 = Slight Discordance in Care
      4 = Moderate Discordance in Care
      5 = High Discordance in Care

REFERENCES

Centers for Medicare & Medicaid Services; Conditions of Participation for Hospitals; Medical Staff
The Joint Commission: MS.08.01.01, MS .09.01.01, MS.13.01.01
Hackettstown Regional Medical Center Administrative Policy: AD 96
Hackettstown Regional Medical Center Medical Staff By-Laws: Article XI,11.01:1(xi), 11.03:2 (i) (ii), 11.03:3
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