

TITLE: PROFESSIONAL PRACTICE EVALUATIONS

POLICY:

Professional Practice Evaluations (PPE) are performed at the direction of the Medical Board and represent a non-biased, fair, and comprehensive physician led activity to measure, assess and, where necessary, improve performance and clinical care throughout the organization. Professional Practice Evaluations include Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation.

PURPOSE:

To define the process by which the Hospital conducts Ongoing Professional Practice Evaluations (OPPE) and Focused Professional Practice Evaluations (FPPE). The goals of Professional Practice Evaluations are to:

- Improve the quality of care provided by individual practitioners who exercise their clinical privileges at the Hospital.
- Monitor the performance of practitioners who have clinical privileges

APPLICABILITY:

This Policy applies to all healthcare practitioners (herein after "practitioners") appointed by the Hospital in accordance with the Medical Staff Bylaws which includes members of the medical, professional associate, nurse practitioner, midwifery and graduate medical staff of The New York and Presbyterian Hospital.

DEFINITIONS:

1. Peer: an individual who practices in the same profession as the practitioner being reviewed or one who is credentialed at a higher level (i.e. physician can review a physician assistant, Psychiatrist can review a psychologist, etc). A peer reviewer should not be an individual who was directly involved with the care of the patient whose case is under review. However, opinions and information may be obtained from those individuals. The level of subject matter expertise required to provide meaningful evaluation for peer review of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example:

- a) For clinical issues related to general medical care, an attending physician may review the care of another physician

- b) For specialty-specific clinical issues, such as evaluating the technique for performing a specialized surgical procedure, a peer is an individual who is trained and experienced in that surgical specialty and performing that specialized procedure.
- c) For FPPEs, the Chief Medical Officer (CMO) or designee shall determine the degree of subject matter expertise for an individual to be considered a peer.

2) OPPE: a process for identifying professional practice patterns or trends that may impact quality of care and patient safety. Review of the information obtained through OPPEs occurs no less frequently than every 12 months. The Medical Staff Office may accept peer reference evaluations in lieu of an OPPE for physicians with consulting privileges.

3) FPPE: a time-limited period during which the Hospital evaluates and determines a practitioner's competence to perform specific clinical privileges.

A Focused Professional Practice Evaluation is conducted when:

- a) Request for a new privilege from a currently privileged practitioner; and
- b) Request for privileges from an applicant for initial appointment to the medical staff.

The time period for conducting a FPPE under the above two (2) circumstances shall be a minimum of three (3) months, or, at the discretion of the Clinical Service Chief, a certain number or percentage of procedures performed during a time-limited period.

The Medical Staff Office will send reminders every three (3) months to Departmental Chairs in order that he/she may assess adequacy of clinical activity and performance quality. The department will either:

- A) Continue the FPPE if inadequate number of cases have been performed [as stated on the Delineation of Privileges (DOP)],
- B) Discontinue the FPPE if the pre-specified number and quality of cases has been performed,
- C) Continue FPPE if a question of quality continues, or
- D) Discontinue the FPPE if the pre-specified parameters of the practitioner's performance have been successfully met.

In addition, a "for cause or triggered" FPPE will be triggered when:

- c) There are concerns regarding clinical activity and performance quality. Issues that will trigger the need for FPPE for cause include:
 - 1. A significant event directly or indirectly attributed to the practitioner.
 - 2. Failure to follow standard of care based on evidence-based practice.

- d) Other events that may warrant consideration of a triggered FPPE include, but are not limited to:
1. Specific questions of clinical competence, patient care and treatment, case management.
 2. A substantiated number of patient, family, staff, or peer complaints.
 3. Inappropriate or disruptive behavior as referenced in Policy C155 DISRUPTIVE BEHAVIOR/ BEHAVIORS THAT UNDERMINE A CULTURE OF QUALITY, SAFETY AND COMPASSIONATE CARE; or
 4. Violations of applicable ethical standards; the Medical Staff Bylaws, Rules & Regulations, or Policies & Procedures; the Corporate Bylaws; or the Code of Ethical Conduct.

In addition a triggered FPPE may be conducted for any other circumstance where the Vice President and Chief Medical Officer for Medical and Professional Affairs, Chief Medical Officer, or Clinical Service Chief is concerned about the practitioner's current competency to perform his/her specially delineated clinical privileges.

PROCEDURE:

1. Each Departmental Clinical Service Chief is responsible for directing and overseeing the Professional Practice Evaluations within his/her respective departments.
2. Clinical Service Chiefs designate participants for PPEs. Such participants may include the Departmental Quality Chairs and /or other professional or clinical staff if deemed necessary and appropriate.
3. The Clinical Service Chiefs are responsible for recommending to the Medical Board criteria to be used for conducting professional practice evaluations in their respective departments. The criteria used in conducting OPPEs and FPPEs may include, without limitation, the following:
 - a) Length of stay that deviates from the Departmental benchmarks.
 - b) Mortalities.
 - c) Unexpected complications as defined by the Clinical Service Chief.
 - d) Third Party Quality Referrals (i.e., from The Joint Commission on Accreditation of Hospitals or from IPRO).
 - e) Medical Record reviews for required documentation, timeliness of completion, and legibility of chart entries.
 - f) Patient experience data and patient complaints.
 - g) Significant adverse drug events.
 - h) Discrepancy between initial/pre and final/post diagnoses such as for radiology, diagnostic or operative procedure.

- i) Unplanned removal or repair of an organ or part of an organ during operative procedure.
 - j) Unplanned return to the operating room.
4. Information obtained from the following sources may be reviewed in the course of conducting Professional Practice Evaluations: medical records, clinical practice patterns; patient complaints; proctoring; external peer review; discussion with other individuals involved in the care of the patient whose case is under review; and any other relevant information deemed appropriate by the Clinical Service Chief.

Professional Practice Evaluation data is reported to the Credentials Committee of the Medical Board. Specific concerns should be escalated to the President and Vice-President of the Medical Board and the appropriate campus CMO.

5. The Hospital will use the practitioner-specific evaluations and, as appropriate, information from Performance Improvement activities in its credentialing and privileging processes.
6. PPEs may be conducted retrospectively by screening aggregate data in comparison with established benchmarks or norms, and reviewing specific events and/or occurrences as described in this Policy. The collection and initial screening of aggregate data will be performed as follows:
- a) Data is collected and an initial screen is performed on an ongoing basis by each Clinical Department's Quality and Patient Safety (QPS) Committee.
 - b) The collection of Practitioner specific data uses a variety of methods including, but not limited to, computerized abstracts of patient cases based on ICD-10 codes or DRG's, pathology reports, autopsy logs and reports, manual logs, and internal or external databases.
7. The results of the initial screen shall be documented and maintained as confidential and privileged Quality and Performance Improvement documents. The record of all cases reviewed, including those referred for focused peer review, will be maintained by the Departmental QPS Committee.

EXTERNAL PERFORMANCE EVALUATION:

1. External performance monitoring may be required when:
- a) There is no internal expertise (i.e. no practitioner has adequate expertise in the specific privilege under review or when the practitioner with expertise is determined to have a conflict of interest with the practitioner under review).

- b) When a practitioner seeks privileges to utilize technology that is new to the Hospital and the Hospital does not have the expertise to review the quality of care.
 - c) In any other circumstance deemed necessary by the Medical Board.
2. The decision of whether an external professional practice evaluation is necessary shall be the decision of the CMO.
3. All data and information collected and maintained in accordance with this Policy is privileged, confidential, and not discoverable in accordance with the Medical Staff Bylaws, New York State Public Health and Education laws and regulations, and federal laws and regulations.

RESPONSIBILITY:

Medical Staff Office

POLICY DATES:

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