

NAMSS QUALITY TOOLKIT FOR MSPS

Compilation of information to equip MSPs with the knowledge, interest, and skillset to inform and influence quality processes at their organizations

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Disclaimer

This resource is a compilation of information to equip medical services professionals (MSPs) with the knowledge, interest, and skillset to inform and influence quality processes at their institutions.

This information was collected by National Association Medical Staff Services (NAMSS) members and NAMSS staff and compiled by NAMSS and its strategic partners to provide a rapid-access Hospital Quality Toolkit for MSPs and hospitals.

This Toolkit is not intended as guidance from NAMSS. It does not replace or serve as a substitute for regulations, accreditation standards, or policy. This Toolkit is solely an informational product offered by NAMSS to MSPs and to hospitals.

NAMSS will update this document on an on-going basis to ensure all new and innovative approaches are reflected to provide states with strategies to continue addressing hospital closures. MSPs may submit updates to info@namss.org, ATTN: Quality Toolkit.

Objectives

This Toolkit focuses on practitioner-quality data and provides hospital/ambulatory quality information that is applicable to Medical Service Professionals (MSPs). Tomorrow's MSP must be prepared to learn new areas of patient safety, which include practitioner quality and hospital/ambulatory quality data, assessment, and management.

Many MSPs may already have a role in the quality realm at their organizations. Others may not, are hesitant to be involved, or do not know where to start. This Toolkit will assist MSPs, wherever they are in the quality space, on their journeys.

Overview

MSPs' main mission is to protect patient safety. This begins with credentialing and privileging, as well as reviewing practitioner-quality data with physician leaders. MSPs collaborate with many departments and personnel to assess practitioner quality, patient safety, patient experience, and risk management. Data is essential to the above assessments and identifying and abstracting relevant data can be the biggest challenge in measuring quality.

Physician leadership, quality personnel, and MSPs need to collaborate to establish systems, processes, and policies to address the different quality indicators that help ensure patient safety and excellent care. MSPs play a key role in helping to assess this quality and have many opportunities within their organizations to improve quality processes. This Toolkit applies to MSPs in ambulatory care, hospital (acute/critical access), specialty hospital, telemedicine, rehabilitation facility, or one in the many other healthcare settings.

Introduction

NAMSS' Quality Toolkit for Medical Service Professionals will help MSPs from entry-level to managerial develop their familiarity with existing quality organizations' policies and processes for assessing quality—and identify quality process-improvement opportunities within their institutions. While quality measurement can be challenging to perfect, MSPs' skillsets and perspectives make them valuable contributors to these efforts.

Tomorrow's MSP must be nimble and embrace such opportunities to promote their careers, evolve with the changing healthcare landscape, and increase job-satisfaction rates. In setting multi-year career goals, MSPs should assess quality measurement processes at their institutions and consider the role they could play in shaping and improving these processes. *NAMSS' Tomorrow's MSP Job Description Builder - Essential MSP Responsibilities and Skills* is an excellent resource for incorporating this information into your career goals.

This Toolkit will focus on practitioner-quality assessment, which measures and evaluates the patient-care data used to determine practitioner performance. This is different from reviewing hospital data, group data, or department data because it requires a standard process for identifying and collecting individualized data elements that measure practitioner competency. This data can be difficult to obtain due to:

- Small patient populations.
- Incomplete data sources.
- Lack of standardized information systems.
- Lack of consensus on appropriate measures.
- Attribution rules for assigning patients to practitioners.
- Benchmark calculations and peer-group assignments comparing physician performance.¹
- Data-accuracy confirmations and processes for auditing and validating the results.

These challenges, though, can present opportunities for MSPs because of their familiarity with identifying elements that reflect practitioner quality and navigating systems to acquire such data. MSPs can also learn from the above challenges and contribute to process-improvement initiatives for obtaining practitioner quality data.

MSP Roles and Opportunities in Quality

Quality-Improvement Processes

As the healthcare landscape continues to evolve, opportunities for MSPs to expand upon—and enhance—their current skillsets continues to increase. Quality is one such example and is most likely one where MSPs can make significant contributions, alongside quality personnel, to improve patient safety. Experience in quality can increase MSPs' confidence and opportunities within their organizations' leadership suite and elevate their value within their institutions.

¹ It is difficult for a healthcare organization to obtain data that adequately captures quality indicators for a specialty and compare it to its practitioners in that specialty. These assessments typically require national benchmark data, which can be a challenge to obtain. Without this data, however, an organization cannot adequately compare its practitioners against broader benchmarks.

It is thus important for MSPs to build relationships with the physician leaders, administrators, and other department directors/managers at their facilities. If MSPs are not involved in quality at their institutions, they should discuss their potential role in, and related contributions to, improving quality mechanisms with their facilities' leadership. If MSPs do not yet have familiarity with the quality space, they may want to identify a quality leader who would consider mentoring them.

Practitioner Wellness

Systematic emphasis on practitioners' professionalism, teamwork, and wellness are more important in healthcare—and common factors in approaching quality discussions. These discussions provide ample opportunities for MSP contributions, particularly with regard to obtaining self-reported and peer-reported data from practitioners. As with competency, practitioner wellness plays a critical role in assessing quality, and many quality programs provide systematic guidance to facilities to help enhance and improve practitioner wellness and performance.

Vanderbilt University offers two practitioner-wellness programs: the Center for Professional Health (CPH) and the Center for Patient and Professional Advocacy. Its CPH addresses practitioners' professionalism and well-being, through programs and retreats at their Center for Health and Wellness in Nashville, Tennessee. The CPH seeks to provide training, knowledge, tools, and practices that administrators and practitioners can use to prevent and overcome burnout and distress. It also provides resources to help practitioners improve work relationships, communicate more effectively, and find deeper joy in their work.²

Vanderbilt's Center for Patient and Professional Advocacy (CPPA) uses the PARS® (Patient Advocacy Reporting System) and CORS (Co-worker Observation Reporting System) to explore patient-wellness programming options for healthcare facilities.³ PARS and CORS use local and national data and established benchmarks to identify and address practitioners who demonstrate behavior inconsistent to their health system's core values and professional expectations.

Mercy Health System is an example of a healthcare system that uses the CPPA to educate and coach practitioners. Diane Meldi, MBA, CPCS, CPMSM, FMSP, then Executive Director – Medical Staff, Mercy Quality & Safety Center, worked with physician leaders to implement these programs throughout the Mercy system.

² Vanderbilt University Medical Center. The Center for Professional Health. <https://medsites.vumc.org/cph/home>.

³ Vanderbilt University Medical Center for Patient and Professional Advocacy. <https://www.vumc.org/patient-professional-advocacy/vumc-cppa-home>

“It was one of the most fulfilling responsibilities that I had and felt like it made a difference in patients and co-worker’s lives,” Diane said. “As an MSP, it is important to be excited and embrace these new areas of responsibility.”

The Mayo Clinic’s Program on Physician Well-Being facilitates research pertaining to physician wellness and performance. Its research to date demonstrates that that physician burnout can affect the patient care, patient satisfaction, access to care, and physician well-being. Physician wellness is a growth opportunity for the MSP, as it requires engaging with hospital administration, physician leaders, and medical staff.⁴

Programs such as Vanderbilt CPH and CPPA, and the Mayo Clinic’s Program on Physician Well-Being, are also resources for MSPs who seek to engage and take leadership in quality processes at their institutions.

Challenges with FPPE and OPPE

MSPs know the challenges of compiling data for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) and how these challenges affect FPPE and OPPE management. Derived from billing data, FPPE and OPPE information needs to be risk adjusted before organizations can use it to assess quality. An organization may collect other data from specialties—radiology, surgical, etc. to inform quality assessment and MSPs should be aware of the unique methods for collecting data for:

- Telemedicine (chart reviews, complaints, timeliness of consultation).
- Ambulatory Care.
- Advance Practice Clinicians (APCs)
 - Billing is usually under the supervising/collaborating physician.
 - For electronic medical records, APCs should add themselves to their healthcare teams in their patients’ records.
 - APCs may also need to keep their own procedural logs to document their clinical privileges. Chart reviews may be the only option if electronic data is not accessible.

⁴ Mayo Clinic Program on Physician Well-Being. [About the Program - Program on Physician Well-Being - Mayo Clinic Research](#)

Interdepartmental Collaboration in Quality

MSPs can work collaboratively with the many departments and offices within an organization such as the quality department, risk-management personnel, and medical staff leadership. MSPs should understand their institutions' quality and peer-review policies and procedures, as well as Medical Staff Bylaws, which address these areas. If not in place, MSPs should consider working with their organization's leadership to establish a standing joint meeting with the above groups to discuss any quality concerns/peer review cases so all relevant personnel have the same information and receive action plans.

Physician leaders are often exasperated over the lack of succinct communications among departments regarding practitioner performance. MSPs can help lead efforts to develop inter-departmental communication plans and use secure software systems to store this information and grant access as appropriate. A software system eases the burdens of reporting peer review, OPPE, FPPE, and helps keep an organization in compliance.

Healthcare Quality

Defining and delivering quality healthcare is a central mission to healthcare organizations all over the world. The Institute of Medicine (IOM) defines healthcare quality as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."⁵

⁵Busse R, Klazinga N, Panteli D, et al., editors. *Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies*. Health Policy Series, No. 53. European Observatory on Health Systems and Policies; 2019. <https://www.ncbi.nlm.nih.gov/books/NBK549277/table/Ch1-t0001/?report=objectonly>.

In 2018, the World Health Organization cited the following reasons for (re)focusing on quality:

- Belief in and commitment to quality healthcare as a public good.
- Growing awareness of gaps in safe, effective, and person-centered care.
- Increasing concerns about substantial practice variations in standards of healthcare delivery.
- Renewed emphasis on improving patient outcomes in the context of currently popular value-based healthcare ideas.
- Expectations from the public, media, and civil society, with a growing public demand for transparency and accountability.
- Drive toward universal health coverage and the understanding that improvements in access without appropriate attention to quality will not lead to the desired population health outcomes.
- Growing recognition of the need to align the performance of public and private healthcare delivery in fragmented and mixed health markets.
- Increasing understanding of the critical importance of trusted services for effective preparedness for outbreaks or other complex emergencies.⁶

Many hospitals and accrediting bodies, use the American College of Graduate Medical Education's (ACGME) six Core Competencies as standards in evaluating practitioners. ACGME's six core competencies are as follows:

1. Patient Care
2. Medical Knowledge
3. Practice Based Learning and Improvement
4. Interpersonal and communication skills
5. Professionalism
6. System-based practice.⁷

Implemented in 2013, the ACGME launched *Milestones*, competency-based developmental outcomes for residents and fellows to demonstrate throughout their education and into their practice.⁸ *Milestones* help emphasize patient safety and quality measures via ACGME's six Core Competencies in residency and fellowship program curriculums. ACGME's *Milestones 2.0* focuses on all specialties and uses the Society to

⁶ Busse R, Klazinga N, Panteli D, et al., editors. *Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies*. Health Policy Series, No. 53. European Observatory on Health Systems and Policies; 2019. <https://www.ncbi.nlm.nih.gov/books/NBK549277/>

⁷ American College of Graduate Medical Education. Six Core Competencies. The Milestones Guidebook for Residents and Fellows. 2020. <https://www.acgme.org/globalassets/pdfs/milestones/milestonesguidebookforresidentsfellows.pdf>.

⁸ ACGME Milestones FAQ. <https://www.acgme.org/globalassets/milestonesfaq.pdf>

Improve Diagnosis in Medicine's (SIDM) competency framework in diagnostic reasoning to develop Medical Knowledge and Patient Care competencies.⁹ ACGME uses SIDM competency framework in diagnostic reasoning to guide all *Milestones 2.0* Work Groups in their development of revised Medical Knowledge and Patient Care competencies.¹⁰

ACGME's vision statement, which focuses on professionalism and quality, can be a helpful resource for healthcare organizations developing quality frameworks for their medical staffs:

Vision: ACGME envisions a health care system where the Quadruple Aim has been realized. ACGME aspires to advance a transformed system of graduate medical education with global reach that is:

- Competency-based with customized professional development and identity formation for all physicians;
- Led by inspirational faculty role models, overseeing supervised, humanistic, clinical educational experiences;
- Immersed in evidence-based, data-driven, clinical learning and care environments defined by excellence in clinical care, safety, cost effectiveness, professionalism, and diversity, equity, and inclusion;
- Located in health care delivery systems equitably meeting local and regional community needs; and,
- Graduating residents and fellows who strive for continuous mastery and altruistic professionalism throughout their careers, placing the needs of patients and their communities first.¹¹

As an example, Mercy Health System's competency framework for practitioners include:

- Professionalism
- Patient Care and Procedural Skills
- Medical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- System-Based Practice.

See Appendices for National Accreditation Standards pertaining to Quality.

⁹ ACGME. Coalition to Improve Diagnosis in Medicine. <https://www.improvediagnosis.org/coalition/>

¹⁰ ACGME. Milestone 2.0. <https://www.acgme.org/globalassets/PDFs/Milestones/Milestones2.0EffectiveDates.pdf>

¹¹ ACGME Vision Statement. <https://www.acgme.org/About-Us/Overview/Mission-Vision-and-Values>.

Quality Resources

The Toolkit's appendices provide examples of resources and policies that healthcare organizations use to facilitate quality assessments for their practitioners. They include the following:

- Appendix A: Baystate Health Low-Volume-No Volume Practitioner Policy
- Appendix B: Baystate Health Focused Professional Practice Evaluation Policy
- Appendix C: Baystate Health Ongoing Professional Practice Evaluation Policy
- Appendix D: Baystate Health OPPE Indicators by Hospital Department Policy
- Appendix E: Baystate Health Department Chair/Service Chief OPPE Response¹²
- Appendix F: Centura's Quality Professional Practice and Peer Review Guide¹³
- Appendix G: New Bridge Medical Center Wellness Committee Policy¹⁴
- Appendix H: ACGME's Core Competencies
- Appendix I: DNV Accreditation Standards
- Appendix J: The Joint Commission Accreditation Standards
- Appendix K: Accreditation Association for Ambulatory Health Care
- Appendix L: CMS Regulations
- Appendix M: NPDB Glossary of Terms

Organizations and Entities that Assess Quality

The Leapfrog Group

The Leapfrog Group, a nonprofit watchdog organization, collects, analyzes, and disseminates data to help inform consumers and value-based purchasing decision-making.

The Leapfrog Hospital Safety Grade uses patient-safety criteria to assess approximately 3,000 hospitals across the United States. The Safety Grade's scoring method is publicly accessible and derived from national, publicly reported patient-safety data. The Leapfrog Group publishes its scoring data in ***The Journal of Patient Safety***.

¹² A sincere thank you to Roxanne Chamberlain, MBA, FACHE, FMSP, CPMSM, CPCS, CPHQ, Senior Director, Medical Staff Services at Baystate Health, Inc. (NAMSS Past President), who provided the above Baystate resources for FPPE, OPPE, and low-volume practitioners.

¹³ A sincere thank you to Aimee Woolley-Randall, BA, MHA, CPCS, CPMSM, FMSP System Director, Medical Staff Services for Centura Health who provided Centura's Quality and Professional Practice and Peer Review Guide.

¹⁴ A sincere thank you to Chris Hinton, CPCS, CPMSM MSP, President NAMSS (2022) for providing New Bridge Medical Center's Wellness Committee Policy.

The Leapfrog Hospital Survey is an annual, voluntary survey of U.S. hospitals that reports on three questions:

- How do hospital patients fare?
- What resources are needed to care for them?
- What management practices promote safety?

Employers, health plans, vendors, and others use Leapfrog data to provide guidance on benefits plans, highlight high-performing hospitals, and inform the public about the performance track of their local facilities. The Leapfrog Group data assessments are important for MSPs to understand and access regularly. They cover a range of quality measures and clinical privileges pertinent to MSPs and can help MSPs delve further into quality processes at their organizations.¹⁵

HCAHPS Survey Overview

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is a national standard for collecting and reporting patients' experiences of hospital care. Its standardized method allows consumers to compare local hospitals and against national data.

The HCAHPS survey seek to 1) collect patient-sourced data so the public can compare hospitals on a specific healthcare service; 2) provide hospitals specific quality-improvement incentives; and 3) enhance accountability among hospital entities.¹⁶

National Quality Forum (NQF)

The National Quality Forum (NQF) sets healthcare standards to improve outcomes and make quality care more accessible and affordable. Known for its rigor and comprehensive evaluation, NQF endorses measures to help healthcare entities achieve specific outcomes. The Centers for Medicare and Medicaid Services and many private-sector entities, use NQF measures to inform their standards.¹⁷

Agency for Healthcare Research and Quality (AHRQ)

A U.S. Department of Health and Human Services subset, the Agency for Healthcare Research and Quality (AHRQ) seeks to produce evidence to improve healthcare safety, quality, and accessibility. AHRQ specifically invests in research to develop pathways for

¹⁵ The Leap Frog Group. <https://www.leapfroggroup.org>.

¹⁶ HCAHPS Overview. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS>

¹⁷ The National Quality Forum. https://www.qualityforum.org/what_we_do.aspx

healthcare improvement, creates resources and processes for healthcare entities to use in improving care delivery, and synthesizes data to inform process improvement in healthcare.

AHRQ Core Competencies:

- Health System Research: AHRQ invests in research to generate data that informs high-quality, safe, and high-value healthcare.
- Practice Improvement: AHRQ develops resources and strategies that health systems and frontline clinicians use to deliver high-quality, safe, and high-value healthcare.
- Data & Analytics: AHRQ data and analysis help healthcare decision makers understand the U.S. healthcare system and identify improvement opportunities.¹⁸

National Association for Healthcare Quality (NAHQ)

Founded in 1976, the National Association for Healthcare Quality (NAHQ) develops industry-standards to help healthcare entities provide consistent, high-quality care. NAHQ's Certified Professional in Healthcare Quality, the CPHC® is the only accredited certification for healthcare quality. With close to 9,000 members, NAHQ seeks to inform efforts to improve healthcare delivery through a set of competencies, "Workforce Competencies for Healthcare Quality Professionals."¹⁹

Institute of Medicine

The IOM recognizes five competency focuses for healthcare professionals: 1) patient-centered care; 2) interdisciplinary teams; 3) evidence-based practice; 4) quality improvement, and 5) informatics. Frameworks for each of these competencies helps inform curriculums and criteria across healthcare disciplines.²⁰

The National Practitioners Data Bank

Hospitals play a critical role in ensuring practitioners' competence and conduct is available to peers through the National Practitioners Data Bank (NPDB) Guidebook. Administered by HHS' Health Resources and Services Administration, the NPDB Guidebook is a comprehensive resource for reporting to, and obtaining practitioner data for all healthcare-entity types. The NPDB requires—and relies upon—timely submissions to protect patients and the public.²¹

¹⁸ Agency for Healthcare Research and Quality. <https://www.ahrq.gov/cpi/corecompetencies/index.html>

¹⁹ National Association for Healthcare Quality. <https://nahq.org/about-nahq/>

²⁰ Institute of Medicine.

https://journals.lww.com/jhqonline/Fulltext/2021/10000/Why_Competency_Standardization_Matters_for.2.aspx

²¹ National Practitioner Data Bank. The NPDB Guidebook. <https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp>

Reportable actions include healthcare-related adverse actions and medical malpractice payments. See [Chapter E of the NPDB Guidebook](#) for an in-depth explanation of reporting guidelines or see [NPDB's Reportable Actions Table](#) for examples of reportable information.^{22, 23}

Peer Review

Medical staff peer review is another important factor in assessing quality and current competency. NPDB defines formal peer review as "the conduct of professional review activities through formally adopted written procedures which provide for adequate notice and an opportunity for a hearing."²⁴

Peer-review statutes vary by state, so MSPs need to be familiar with their state-specific requirements. The law firm, *Horty, Springer & Mattern*, provides helpful links to state criteria in its [Peer Review Statutes by State](#) compilation.²⁵ MSPs should also review recent legal cases pertaining to peer review to help inform their organizations' evolving peer-review processes and Medical Staff Bylaws.

Quality Resources

<u>Name of Organization</u>	<u>Website</u>
Accreditation Association of Ambulatory Healthcare	https://www.aaahc.org/
Accreditation Commission for Health Care (HFAP)	https://www.achc.org/
Accreditation Council for Graduate Medical Education	https://acgme.org
Agency for Healthcare Research	https://ahrq.gov
American Society for Healthcare Risk Management	https://www.ashrm.org/
Centers for Medicaid and Medicare Services	www.cms.gov

²² <https://www.npdb.hrsa.gov/guidebook/EOOverview.jsp>

²³ <https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp>

²⁴ National Practitioner Data Bank. Peer Review Definition. <https://www.npdb.hrsa.gov/faqs/r7.jsp>

²⁵ Horty, Springer & Mattern. Peer Review Statutes by State. <https://www.hortyspringer.com/peer-review-statutes-by-state/>

DNV	https://www.dnv.com
Health Resources & Services Administration	www.hrsa.gov
Institute for Healthcare Improvement	http://www.ihl.org/
Leapfrog Group	www.leapfroggroup.org
National Association Healthcare Quality	www.nahq.org
National Committee Quality Assurance	www.ncqa.org
The Joint Commission	www.jointcommission.org
URAC	https://urac.org

Conclusion

Assessing practitioner quality is critical to ensuring patient safety and excellence at a healthcare facility. And while quality processes present challenges, they also present opportunities for those with expertise—MSPs—to help establish or improve processes for assessing quality.

MSPs experience firsthand the pain points of an inefficient processes. They understand them well and can provide fresh, but well-informed insight for troubleshooting and improving processes. MSPs' perspectives can help assess existing quality processes and protocols to ensure a facility's functionality, nimbleness, and ability to provide safe and high-quality care to the community it serves.

The NAMSS Hospital Quality Toolkit provides MSPs with knowledge and resources on quality processes, as well as examples of MSPs taking part in—or leading—quality efforts at their facilities. MSPs' expertise and insight will help develop, promote, and enhance successful hospital credentialing programs. NAMSS continues to serve as a resource for MSPs partaking in this critical work. Please send any questions about the Hospital Quality Toolkit to info@namss.org.

Appendices

Appendix A

Baystate Health Low-No Volume Practitioner Policy

Policy: To provide guidance to each Department Chair (or designee) of what to do when there is little or no clinical data to complete the required Joint Commission Ongoing Professional Practice Evaluation cyclical review in relation to clinical privileges.

Purpose: To outline specific permissible options for low-no volume practitioners.

Goals:

1. Ensure that the Ongoing Professional Practice Evaluation process is clearly defined in relation to low/no volume practitioners.
2. To provide options when there is not enough clinical data to assess the competence of practitioners who are granted clinical privileges
3. Foster patient safety.

Definitions:

1. Ongoing Professional Practice Evaluation: The evaluation of an individual practitioner's professional performance for the purpose of identification of opportunities to improve his or her performance. It differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system.
2. Low to No Volume Practitioner: A practitioner who lacks performance data because he/she does not practice at the hospital regularly, if at all. This type of practitioner often refers patients to the hospital or to other members of the medical staff, participates in community outreach programs on behalf of the hospital, and provides a continuation of care for patients after they are discharged from the hospital, offering patients a sense of community.

3. Competency: The Joint Commission has adopted the six competency categories and definitions of competent medical practice developed by the Accreditation Council for Graduate Medical Education (ACGME): Baystate Health uses these competency statements to identify measures of performance for each of the six competency areas, and bases individual's evaluation on these, and generally recognized standards of care. Through the process of Ongoing Professional Practice Evaluation (OPPE), practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice in the following competency categories:
- a. 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 at the end of life.
 - b. Medical 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.
 - c. Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
 - d. 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.
 - e. 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.
 - f. 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 healthcare.

Procedure: Ongoing Professional Practice Evaluation provides standardized processes for continuous evaluation of professional practice during the time between initial appointment and biannual reappointments. When there is little to no clinical data, the department chair or designee have the following options, keeping in mind that the burden of documentation is ultimately placed on the practitioner:

- a. External Sources: If a practitioner does not perform the minimum number of procedures required or meet other criteria, the practitioner can obtain data from other facilities where he/she holds similar privileges to submit to the Baystate Health Medical Staff Office for review by the Department Chair or designee. The practitioner would be required to contact the Quality Department at these other facilities to obtain this information as often times this information will only be released to the actual practitioner.
- b. Authoritative Peer References: When there is insufficient peer review data available from any source (which could be due to the nature of the practitioner's specialty, etc.), per the Joint Commission, the Medical Staff Office can obtain authoritative peer reference(s) that can attest to the practitioner's competence to perform the clinical privileges requested. Baystate Health will select two authoritative sources if available, typically a peer in a position of authority at the alternative facility. The practitioner under review would not select the source. If no authoritative peer references are available, may consider regular peer references instead.

Note: Sometimes authoritative peer references or regular peer references cannot be obtained if the practitioner has not performed clinical privileges during the previous 24 months. In that event, the practitioner is unable to provide evidence of ongoing clinical competence, and there may be no real basis for continuing clinical privileges.

When deciding whether there is sufficient information to continue specific privileges, the organization may also evaluate whether the applicant for renewal has sufficient evidence of ongoing clinical activity and competence in advanced privileges. If the applicant meets the criteria for advanced privileges, the organization may determine that he/she may also meet the privileging criteria for less complex privileges that require related skills and knowledge.

- a. Affiliated Staff Category: Move the practitioner to the affiliated staff category. If moved to this category, it means the practitioner has membership with no clinical privileges and then an OPPE does not have to be completed.

- b. Members can still serve on committees, hold office, and vote at Medical Staff Meetings (please refer to the Medical Staff Bylaws regarding the categories of the Medical Staff). If the practitioner is not in favor of this change in category, has no clinical activity and cannot provide clinical data from an external source or two authoritative peer references, then the practitioner may be terminated.

Other Considerations:

- If there is insufficient data for one review period, the department chair or designee may elect to continue monitoring the patient care provided by the practitioner. However, if there are two consecutive periods of insufficient information, the organization might elect to obtain two authoritative external peer references regarding the performance of similar privileges at the practitioner's primary practice location.
- If a practitioner has a low amount of patient encounters or cases at Baystate Health during a review period, the organization may conduct a case review at the next available opportunity.
- Associate Professionals who provide direct patient care services at the hospital under a defined degree of supervision by a physician medical staff member who has been granted clinical privileges and is credentialed and privileged through the Medical Staff are also subject to OPPE. The Joint Commission expects that the same surveillance and peer review for physicians will apply to Associate Professionals as well. **NOTE:** When applicable, mid-level practitioners will be requested to keep a list of their patient records by account number (corporate medical record number) so a report can be pulled by their supervising physician's name as the patients are most likely going to be listed under their supervising physician's name.

Appendix B

Baystate Health Focused Professional Practice Evaluation (FPPE) Policy

Policy: Baystate Health will perform Focused Professional Practice Evaluations (FPPE) on all practitioners when any of the following circumstances exist:

- a. Practitioners new to Baystate Health are requesting credentials and privileges. For these practitioners, focused review will include all privileges requested.
- b. Existing Medical Staff members are requesting new privileges. For existing practitioners, focused review will include the new privileges requested.
- c. For a documented concern regarding competence. Triggers and criteria that indicate the need for this circumstance as identified in the individual Baystate hospital's Peer Review Policy.

Baystate Health will conduct FPPE in accordance with this policy and the FPPE Plan will be developed by each Medical Staff Department Chair (Chief at the community hospitals) for each practitioner and specific to each hospital. The FPPE Plan will include the following privilege specific elements:

- a) The criteria that established the need for FPPE.
- b) The method for conducting the plan specific to the requested privilege.
- c) The method for determining duration of the performance monitoring.
- d) The circumstances in which monitoring by an external source is required.

Purpose: To create a systematic process that assures there is sufficient and appropriate information available to confirm the current competency of practitioners granted privileges at Baystate Health. This process provides the basis for obtaining organization specific information that substantiates current competence of practitioners.

Goals:

- a) High quality of care provided by individual practitioners on staff.
- b) Competent new practitioners who are granted privileges.
- c) Competent practitioners who are requesting new privileges.
- d) Restoration (when necessary and possible) of the competence of practitioners for whom concerns about competence have been established.
- e) A process which is clearly defined, fair, timely, useful, and defensible.

Definitions:

1. Competence: The demonstrated capacity to perform desired clinical processes and practices in accordance with established standards and policies. The domains of competence are defined below. The Joint Commission has adopted the six competency categories and definitions of competent medical practice developed by the Accreditation Council for Graduate Medical Education (ACGME).

Baystate Health Medical Staff uses these competency statements to identify measures of performance for each of the six competency areas, and bases the individual's evaluation on these, and generally recognized standards of care. Through the process of Ongoing Professional Practice Evaluation (OPPE), practitioners receive feedback for personal improvement, or confirmation of personal achievement related to the effectiveness of their professional practice.

The six competency categories are:

- (1) 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 at the end of life.
- (2) Medical 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.
- (3) Practice -Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- (4) 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.
- (5) 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.
- (6) 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 healthcare.

2. Assessment: The processes used to gather information to define an individual practitioner's current clinical competence for requested privileges, and for documented concerns. As appropriate, in addition to credentialing, assessment will address the six general competencies described above, and/or the privileges requested. The indicators that are used for OPPE may also be utilized in the FPPE for new practitioners.

3. Proctor (Assessor): A practitioner assigned by a Medical Staff Department Chair (Chief at the community hospitals) to assess competency of a practitioner in one of the circumstances in this Policy statement above.

Roles and Responsibilities:

A. The Department Chair (Chief at the Community Hospitals)

Each medical staff Department Chair (Chief at the community hospitals) shall be responsible for:

1. Developing a specific FPPE Plan, appropriate to the requested privileges for each practitioner under evaluation.
2. Setting the criteria that will be used to judge performance and including them in the plan.
3. Recommending the minimum number of cases/procedures to be assessed and determining when a proctor must be present. The minimum number of cases to be assessed and the type of assessment required shall be made at the time privileges are recommended. When there are any interdepartmental privileges, an FPPE plan will be created for each department per the respective Department Chair (Chief at the community hospitals).
4. Assigning proctors as noted above.
5. If at any time during the proctoring period the proctor notifies the Department Chair (Chief at the community hospitals) that he/she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the Department Chair (Chief at the community hospitals) based on the recommendations of the proctor, shall then review the information regarding the patient(s) treated by the practitioner and may:
 - a. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for the patient
 - b. Refer the case to the Medical Staff Quality and Peer Review Committee
 - c. Recommend to the Medical Staff Executive Committee that:

1. Additional or revised evaluation (proctoring) requirements be imposed upon the practitioner, or
2. Consideration for corrective action is undertaken pursuant to the Medical Staff Bylaws.

B. The Medical Staff Office (MSO):

The Director of Medical Staff Services has administrative accountability for the timely and accurate implementation of the terms of the FPPE Policy, and will assure via the Focused Professional Practice Evaluation Specialist that the following are accomplished:

1. Collaborate with the Department Chairs (Chiefs at the community hospitals) to assure the development of FPPE Plans for each individual Baystate Health hospital as warranted
2. Maintain communication between practitioners, department chairs (Chiefs at the community hospitals) and proctors to include:
 - a. Sending a letter to the practitioner being assessed and to the proctor (if assigned) containing the following information:
 1. A copy of the privilege form of the practitioner.
 2. Practitioner and Proctor (if assigned) contact information.
 3. A copy of this FPPE Policy.
 4. Attestation to be completed by the proctor (if assigned).
 - b. Developing a mechanism for tracking all admissions or procedures performed by the practitioner being assessed.
 - c. Provide information to appropriate hospital departments about practitioners being assessed including the name of the proctor.
 - d. Contact both the proctor and the practitioner on a quarterly basis to ensure that assessment is being conducted as required.

C. Proctor (Assessor):

The proctor's role is that of an assessor, not a consultant or mentor. A practitioner serving as proctor for the purpose of assessing and reporting on the competence of another practitioner is an agent of Baystate Health. The proctor shall receive no compensation directly or indirectly from any patient for this service. The proctor shall have a duty to the patient to intervene if the care provided by the proctored practitioner may result in harm to the patient.

The proctor is expected to report immediately to the appropriate Department Chair (Chief at the community hospitals) and Baystate Health authority (e.g., Senior Vice President for Quality & Patient Safety, Director of Quality & Patient Safety, or the Chief Medical Officer at the respective hospital) any concerns regarding the care being rendered by the practitioner that has the potential for imminent patient harm. The proctor, or any other practitioner, may render emergency medical care to a patient for medical complications arising from the care provided by a practitioner being assessed. Baystate Health will defend and indemnify any practitioner who is subjected to a claim or suit arising out of his or her acts or omissions in the role of proctor.

Proctor(s) must be members in good standing on the respective Medical & Associate Professional Staff and must have privileges in the specialty area relative to the privilege(s) being evaluated. The proctor shall:

1. Use appropriate methods and tools approved by the MSEC for that department, as specified on the Focused Professional Practice Evaluation (FPPE) Plan.
2. Assure the confidentiality of the proctoring results and forms and deliver the completed proctoring forms to the Medical Staff Office in a timely manner as provided for in the FPPE Plan.
3. Submit any summary reports or additional information requested by the Department Chair (Chief at the community hospitals).
4. If the practitioner being assessed is not sufficiently available or lacks sufficient cases to complete the assessment process in the prescribed time frame, the Department Chair (Chief at the community hospitals) may recommend to the Credentials Committee an extension of the proctoring period to complete the report but it can not exceed the initial appointment period.
5. If at any time during the proctoring period the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the Department Chair (Chief at the community hospitals).

D. Responsibilities of the Practitioner Being Proctored:

The practitioner being proctored shall:

1. For concurrent assessment, make every reasonable effort to be available to the proctor including notifying the proctor of each patient whose care is to be evaluated in sufficient time to allow the proctor to concurrently observe or review the care provided. For elective surgical or invasive procedures where direct

observation is required, and the department requires assessment to be completed before the practitioner can perform the procedure without the proctor present, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as reasonably possible.

2. Provide the proctor with information about the patient's clinical history, pertinent physical findings, pertinent lab and radiology results, the planned course of treatment or management, and provide direct delivery to the proctor of a copy of all histories and physicals, operative reports, consultation reports, and discharge summaries documented by the practitioner being assessed.
3. Have the prerogative of requesting from the Department Chair (Chief at the community hospitals) a change of proctor if disagreements with the current proctor may adversely affect his or her ability to satisfactorily complete the assessment. The Department Chair (Chief at the community hospitals) will keep the Credentials Committee and MSEC informed about such changes.
4. Inform the proctor of any unusual incident(s) associated with his/her patients.

E. Responsibilities of the Credentials Committee:

1. Approve the FPPE Plan as part of the credentials review and recommendations plan.
2. Have the responsibility of monitoring compliance with this policy and procedure.
3. Receive regular status reports from the Medical Staff Office related to the progress of all practitioners required to be assessed as well as any issues or problems involved in the implementation of this policy and procedure. This report may be in the form of the then current FPPE log.
4. Make recommendations to the MSEC regarding clinical privileges based on information obtained from the assessment process.

F. Responsibilities of the Medical Staff Executive Committee:

1. Oversee the compliance of all parties with the FPPE process and make recommendations for changes as needed.
2. Review, modify, approve or reject recommendations from the assessment as presented by the Credentials Committee and the Department Chair (Chief at the community hospitals).
3. Direct department chairs to establish standard assessment plans to be modified as needed for individual practitioner needs.
4. Submit for approval to the Board of Trustees recommendations for credentialing which may include the FPPE.

G. Board of Trustees:

1. Assure, as part of the comprehensive credentialing process, that the process for FPPE is followed in accordance with this policy.
2. Approve, modify or reject an application for credentials or privileges.

H. Role of the Quality & Patient Safety Department:

1. The Quality & Patient Safety Department in collaboration with the Medical Staff Office will provide support and data for the FPPE Process.

Procedures:

1. Selection and Methods for Each Specialty:

As part of the recommendation to the Credentials Committee for granting of privileges, the Department Chair (Chief at the community hospitals) will include the FPPE Plan when possible. The Department Chair (Chief at the community hospitals) is responsible to determine the appropriate methods to assess current competency for an individual practitioner in relation to requested/specific privileges.

The Credentials Committee and/or the Medical Staff Executive Committee may modify the FPPE Plan in collaboration with the Department Chair (Chief at the community hospitals). The plan is then included as part of the recommendations for credentials up through the organization to the Board of Trustees. The Board of Trustees may review the FPPE Plan as needed.

2. Assessment Methods:

The evaluation process may utilize any or a combination of the following methods to obtain the best understanding of the care provided by the practitioner:

Prospective Assessment: Presentation of cases with planned treatment outlined, with review of case documentation, case simulation, or completion of a written or oral assessment.

Concurrent Assessment: Direct observation of procedures being performed, or concurrent evaluation of medical management either through observation of practitioner's interactions with patients and staff, or review of clinical history and physical and review of treatment orders during the patient's hospital stay.

Retrospective Assessment: Review of the case record after care has been completed. This may also include interviews of personnel directly involved in the care of the patient.

Off-Site Assessment (documented evidence of assessment and evaluation from another hospital): This may be used in situations where a practitioner has skills that are needed at Baystate Health on an occasional basis and where the skills and reputation of the practitioner being assessed are known to members of the Medical Staff at Baystate Health, or in situations where practitioners are needed from local area hospitals to provide occasional coverage at one of the Baystate hospital's. It is up to the Department Chair (Chief at the community hospitals) to make a recommendation related to the use of off-site assessment for a specific practitioner situation. Temporary privileges as covered in the Bylaws will be used as needed.

3. Sources of Data:

The assessor in accordance with the FPPE Plan may include any or all of the following sources of data and information to complete the evaluation. The data sources and methodology for evaluation will be appropriate and specific to the requested privileges.

- a. Personal interaction with the practitioner by proctor.
- b. Detailed medical record review by the proctor.
- c. Interviews of hospital staff interacting with the practitioner.
- d. Surveys of hospital Medical Staff interacting with the practitioner.
- e. Record reviews based on criteria for initial appointees as defined by the Department Chair (Chief at the community hospitals).
- f. Direct observation of the practitioner while conducting a procedure, interview, or other diagnostic or treatment process.
- g. Aggregate risk and severity adjusted data collected during the period of assessment (if available) and related to the assessment plan.
- h. Information developed as part of the OPPE program.

The data obtained by the assessor will be recorded on the approved FPPE form.

4. Assessment Data Evaluation:

Using established criteria for thresholds, the Department Chair (Chief at the community hospitals) will review both the case-specific and aggregate data, and provide the Credentials Committee with an interpretation as to whether a practitioner's performance was:

- a. acceptable
- b. in need of further data to complete the evaluation
- c. unacceptable.

For aggregate rate data, the acceptable targets will be determined by the individual Medical Staff Department Chairs (Chiefs at the community hospitals).

5. Focused Evaluation Period:

The Evaluation Period shall begin when a practitioner is informed of appointment to the Medical and Associate Professional Staff, upon being granted a new privilege, or at the point when it has been determined that a Focused Review is needed per this policy. Based on the specialty of the practitioner, newly granted privileges shall be considered under FPPE for either a specific period of time and/or for a specific number of patients/procedures.

Most FPPE plans should be completed within three (3) to six (6) months. However, the evaluation period may be extended if either initial concerns are raised that require further evaluation or if there is insufficient activity during the initial period. This extension can be for a period not to exceed a total of twenty-four (24) months from the granting of the new additional clinical privilege(s) or in the case of a "for cause" FPPE. The evaluation period for a new applicant may be extended for a period not to exceed the initial appointment period.

The Department Chair (Chief at the community hospitals) and Credentials Committee may take into account the practitioner's previous experience in determining the approach, duration, and extent of assessment needed to confirm current competency. The practitioner's experience may fall into one of the following categories:

- a. Residency/fellowship training program graduate (training completed within the past two years).
- b. Practitioner with experience at another healthcare organization.

6. Results and Recommendations:

At the end of the evaluation period, the Department Chair (Chief at the community hospitals) shall provide to the Credentials Committee a summary report (in the form of the FPPE plan template provided), which shall include one or more of the following:

- a. Whether a sufficient number of cases done at the respective Baystate hospital or at another local hospital (i.e., via off-site proctoring) have been presented for review to properly evaluate the clinical privileges requested.
- b. Make a recommendation related to the appropriate medical staff category and clinical privileges as requested. If a sufficient number of cases have not been presented for review, whether in the Department Chair's (Chiefs at the community hospitals) opinion, the FPPE period should be extended for an additional period but not to exceed the initial appointment period or that the practitioner be moved to the "Affiliated" medical staff category (membership only).
- c. Recommend that membership and clinical privileges not be approved as requested.

7. Appeals:

If there is a recommendation by the MSEC to terminate a practitioner's appointment, additional, or existing clinical privileges, due to questions about qualifications, behavior or clinical competence, the Medical Staff member shall be entitled to the hearing and appeals process outlined in the Medical Staff Bylaws.

Appendix C

Baystate Health Ongoing Professional Practice Evaluation (OPPE)

Policy: Baystate Health will ensure a comprehensive Ongoing Professional Practice Evaluation Program (OPPE) that is in compliance with the Medical Staff Bylaws, Rules & Regulations, the requirements of the Board of Registration in Medicine, and the Joint Commission, as expressed in this Policy.

Purpose: To outline the components of the OPPE program.

Goals:

- a. Ensure that the OPPE process is clearly defined, fair, useful, timely and defensible.
- b. Ensure high quality of care provided by individual practitioners on the Medical Staff.
- c. Foster patient safety.
- d. Create a culture with a positive approach to OPPE reviews by recognizing practitioner excellence as well as identifying improvement opportunities.
- e. Assess the competence of new practitioners who are granted privileges.
- f. Assess the competence of practitioners requesting new privileges.
- g. Perform ongoing assessment of current practitioners, routine and focused.

Definitions:

1. Ongoing Professional Practice Evaluation: The evaluation of an individual practitioner's professional performance for the purpose of identification of opportunities to improve his or her performance. It differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system.
2. Privileged Information: All "Ongoing Professional Practice Evaluation" review information and documents are privileged and confidential in accordance with Medical Staff and hospital bylaws, state and federal laws and regulations pertaining to confidentiality and non-discoverability.

3. OPPE reviews are conducted using multiple sources of information that may include:
 - a. Review of data from the databases available to the quality division including (i.e., Premier, Midas, Safety Reporting System).
 - b. The review of individual occurrences and aggregate data for compliance with general rules and regulations of the Medical Staff.
 - c. Review of clinical standards of practice processes and outcomes using rates in comparison with established benchmarks, department peers or other generally accepted norms.
 - d. Authoritative Peer references (when applicable).
 - e. Other data sources.
4. Competency: The Joint Commission has adopted the six competency categories and definitions of competent medical practice developed by the Accreditation Council for Graduate Medical Education (ACGME). Baystate Health uses these competency statements to identify measures of performance for each of the six competency areas, and bases individual's evaluation on these, and generally recognized standards of care.

Through the process of OPPE, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice in the following competency categories:

- a. 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 at the end of life.
- b. Medical 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.
- c. Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- d. 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.
- e. 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.

- f. 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 healthcare.

Procedure:

OPPE provides standardized processes for continuous evaluation of professional practice during the time between initial appointment and biannual reappointments. The process identifies what data will be reviewed, how often it will be reviewed, how the data is used to make decisions about continuing, limiting and/or revoking privileges, and how the data from this process ultimately is included in the individual's peer review protected file in the Medical Staff Office.

OPPE Process:

a. Selection and Approval of Indicators for OPPE.

Department Chairs (Chiefs at the community hospitals) approve and recommend to the Medical Staff Executive Committee (MSEC) the specific data and indicators that will be collected and analyzed for ongoing professional practice evaluation. Data and indicators are chosen to reflect the specific privileges of the individual practitioner, and the specialty of practice, and may be specific or broad in scope to reflect the dimensions of competency. For each indicator, Department Chairs (Chiefs at the community hospitals) approve satisfactory or unsatisfactory levels of performance.

MSEC reviews and approves the submitted list of indicators assuring that the correct type and amount of data is being collected. For the most part, each department's indicators may be similar and will reflect the range of privileges granted to members of the department.

Some of the data elements may be the same for all members of the Medical Staff, i.e. complaints, compliments; while others will be specific to the distinct privileges of the individual practitioner; i.e. performance-volume and complications for a specific procedure or typical of the practitioner's specialty. Department Chairs (Chiefs at the community hospitals) will discuss data elements for the practitioner profile with members of their departments to assure their understanding of the measures and seek input on current, new, and revised performance indicators.

Data elements may reflect:

1. Rate-based indicators, e.g. risk and severity adjusted mortality, readmissions, LOS, and complications, benchmarked to best practices, using an approved benchmarking product.

2. Rules indicators, including compliance with evidenced based practice as measured by standardized record abstraction methods and medical staff rules violations such as record completion data, CME status.
3. Occurrences as reported on the Safety Reporting System (SRS) or complaint system, and case reviews completed by the appointed “peer reviewer” and their adjudication. Performance volume data is included in all performance profiles. Sources of data include benchmark data, core measures, retrospective record reviews, observational data, reported occurrences as well as review of cases identified through ongoing screening mechanisms, monitoring of diagnostic and treatment techniques, and the sources as needed to assure that data for the profile is sufficient in scope.

b. Individual Practitioner Profiles

Approximately every eight months but no later than every eleven months, designated staff members of the Quality and Patient Safety Department will create individual Practitioner Profiles (“OPPE Report”) in conjunction with the Medical Staff Office, for each member of the Medical Staff, including that individual’s current performance against the chosen data elements for the department or other aggregated information.

c. Using the Data at the Cyclical Department Chair (Chiefs at the community hospitals) Review

Department Chairs (Chiefs at the community hospitals), and/or their designees, evaluate the individual practitioner performance, as reflected in the OPPE data gathered. Upon completion of the review, the Department Chair (Chief at the community hospitals) will complete the “Department Chair (Chief at the community hospitals)/Service Chief OPPE Report Response Form”, indicating any recommendations and/or comments. Evaluations at the review that are satisfactory, and recommendations to approve continue privileges, are made at the department level and need no further review.

Any practitioner’s cyclical review that results in a level of performance of “unsatisfactory” must be presented by the Department Chair (Chief at the community hospitals) to the appropriate Medical Staff Quality Committee (the actual name of this committee may be different at each of the community hospitals within BH) for its consideration. Special attention needs to be directed to situations in which the practitioner profile indicates low or no volume in a privileged area (please refer to the “Low to No Volume Policy”), to determine if the practitioner is no longer performing the procedure, or not performing the procedure at Baystate Health, or if this is a low volume procedure that has not yet been performed.

Each individual practitioner will receive a copy of the "Department Chair (Chief at the community hospital)/Service Chief OPPE Report Response Form" for review and, as needed, discussion with the Department Chair (Chief at the community hospitals), or other parties involved in the process.

d. Decision Making Beyond the Department Chair (Chief at the community hospitals)
Department Chairs (Chiefs at the community hospitals) will report on the results of their completed cyclical reviews to the appropriate Medical Staff Quality Committee (please refer to the Peer Review Policy specific to the hospital it applies) and will present any reviews resulting in a "low/no volume - needs more data" or "unsatisfactory" recommendation. Recommendations for actions to improve performance, conduct focused reviews and limit or revoke privileges are made by the applicable Medical Staff Quality Committee to the Medical Staff Executive Committee for their consideration and decision.

Recommendations for focused review are carried out in accordance with the provisions of the "Focused Professional Practice Evaluation Policy." Any recommendation, based on data in the OPPE Report or the "Department Chair (Chiefs at the community hospitals)/Service Chief OPPE Report Response Form", which limits or revokes the privileges of an individual practitioner, requires approval of the Board of Trustees in accordance with the provisions of the Medical Staff Bylaws.

Upon completion of the review, the recommendation is placed in the individual practitioner's peer review protected file in the Medical Staff Office along with any summary of actions taken.

e. Integrated into Credentials Process

At reappointment, the Credentials Committee will review the "Department Chair (Chief at the community hospital)/Service Chief OPPE Report Response Forms" in accordance with their processes for reappointment, and will use all other data available to them on the Practitioner Profiles to arrive at their decisions and recommendations.

Focused Professional Practice Evaluation (FPPE):

FPPE is the process for establishing competency for new Medical Staff members, new privileges for existing Medical Staff members, and evaluation of concerns regarding individual practitioner's competency from OPPE and other sources.

Criteria for Focused Professional Practice Evaluation:

Whenever any of the following three criteria are met, a Focused Professional Practice Evaluation will be implemented:

1. A practitioner requests initial membership and privileges at Baystate Health.
2. A member of the Medical Staff requests new privileges.
3. If results of Ongoing Professional Practice Evaluation, or any other source for concern about a practitioner's competency indicates a potential issue with practitioner performance, the Department Chair (Chief at the community hospitals) will initiate a focused evaluation to determine if there is a problem with competency of the practitioner for either specific privileges or for more global dimensions of performance. These potential issues may be the result of information generated in the credentialing and privileging process, from an individual case review, observation during monitoring or proctoring, or from rule or rate indicators, and other such information including the OPPE Reports. Focused Professional Practice Evaluation criteria and Guidelines are described in a separate FPPE Policy.

Statutory Authority:

This policy is afforded protection in accordance with MGL c.111, § 203(d) and M.G.L. c. 112, § 5.

Appendix D

Baystate Health OPPE Indicators by Hospital Department Baystate Medical Center

Department of Anesthesiology

- Volume Data (approximate number of cases and/or pain procedures)
- Code Blue During Anesthesia Care in Operating Room or Remote Sites
- Mortality Review
- Complications or Quality concerns from AQIC, Patients, Surgeons, and Advanced Practitioners. Includes pre-op/intra-op, pain management and post-op events
- Medical Record Delinquencies
- General Competencies Review:
 - Patient care
 - Medical clinical knowledge
 - Practice based learning and improvement
 - Professionalism
 - Systems based practice
 - Interpersonal and communication skills.

Department of Emergency Medicine

For Attendings (and the first three indicators also apply to advanced practitioners):

- 72 Hour Returns to the ED with a Critical Care Admission (adults & pediatrics)
- Mortality/Morbidity Review
- Pneumonia (timing and appropriateness of antibiotics and blood cultures)
- STEMI (PCI within 90 minutes of presentation)
- Stroke (time to thrombolysis measured)
- Delinquent Medical Record Completion (greater than 10 days after visit).

Department of Medicine

- Premier Focus Report:
 - Mortality
 - Complications/patient safety indicators
 - Length-of-stay
 - 30 day readmissions
 - Cost per case (listed on the report but excluded for OPPE)
 - Volume of procedures
 - Resource utilization.

For Advanced Practitioners (chart reviews):

- Patient Care: Acquire accurate and relevant history from patient in a customized and prioritized fashion.
- Medical Knowledge: General knowledge and management of common inpatient medical conditions.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialist, and ancillary services.

Department of OB/GYN

- Premier Focus Report:
 - Mortality
 - Complications/patient safety indicators
 - Length-of-stay
 - 30-day readmissions
 - Cost per case (listed on the report but excluded for OPPE)
 - Volume of procedures
 - Resource utilization.

For Certified Nurse Midwives

- Deliveries
- Episiotomies:
 - Third-degree lacerations
 - Fourth-degree lacerations
 - Apgars – 5
 - NICU admission at delivery
 - Estimated blood loss at delivery
 - OPPE competency form for all CNMs that report to the Division Chief.

Department of Pathology

- Patient Care:
 - Turnaround time of overdue cases
 - Amended reports for major diagnostic error
 - Frozen section-permanent section diagnosis correlation and resolution documentation
 - Outside institution-original diagnosis correlation
 - Critical value communication and documentation
 - Case review agreement (conferences, review past case material for evaluation)
 - Response to request for faculty consultation in clinical laboratory problems
 - Substantiated clinician or patient complaints concern patients/specimens.

- **Medical Knowledge:**
 - Continuing medical education (meetings, conferences, MOC activity, performance improvement programs (CAP))
 - Attendance at resident/clinical conferences
 - Attendance at web based CME conferences (assessments to be performed by peer faculty in clinical pathology).
- **Practice Based Learning and Improvement:**
 - Quality improvement studies
 - Intradepartmental consultation
 - Anatomic pathology review conference.
- **Interpersonal and Communication Skills:**
 - Interdepartmental (interdisciplinary conferences)
 - Hospital administrative committees
 - Clinical attending negative and positive feedback on pathologist performance
 - Educational activities (resident evaluations, teaching, lectures, etc.).
- **Professionalism:**
 - Participation in administrative activities (national professional committees and institutional committees)
 - Availability of attendance (faculty meetings, resident retreat, APRC, etc.)
 - Active participation in support for departmental activities other than routine assignment/scheduled service (APRC, service backup, intradepartmental consultations, etc.)
 - National recognition (society membership, awards, etc.)
 - Editorial board manuscript review participation, and publications
 - National, regional, and institutional invited presentations.
- **Systems Based Practice:**
 - Compliance with practice guidelines
 - Adoption and appropriate utilization of ancillary laboratory diagnostic tools/tests
 - Adoption of information technology tools and advancements
 - Risk management (claims, law suits, and other medico-legal issues)
 - Error reduction participation
 - Adherence to laboratory safety policies and practice.

Department of Pediatrics

- Premier Focus Report:
 - Mortality
 - Complications/patient safety indicators
 - Length-of-stay
 - 30 day readmissions
 - Cost per case (listed on the report but excluded for OPPE)
 - Volume of procedures
 - Resource utilization.

Department of Psychiatry

- Premier Focus Report:
 - Mortality
 - Complications/patient safety indicators
 - Length-of-stay
 - 30 day readmissions
 - Cost per case (listed on the report but excluded for OPPE)
 - Volume of procedures
 - Resource utilization.

Department of Radiology

- Patient Care:
 - Review of RadPeer results
 - Review of cases submitted to the peer review committee
 - Mammography quality control
- Medical Knowledge: Continuing medical education (CME) credits
- Practice Based Learning and Improvement: Attendance at patient safety rounds
- Interpersonal and Communication Skills:
 - Resident evaluations
 - Feedback from providers, patients, and associates
- Professionalism:
 - Participation in hospital administration and education hours
 - Attendance at faculty meetings and department committee meetings
- System Based Practice: RadPeer participation.

For Radiation Oncologists:

- Patient Care:
 - ACR monthly chart review: report unaccepted plan rate
 - Weekly quality assurance rounds, all new radiation prescriptions review: report unsatisfactory plans.
- Medical Knowledge:
 - CME
 - Compliance with national guidelines (NCCN – reviewed at weekly QA; via pathways – pending)
- Practice Based Learning:
 - CME
 - Citizenship (participation in weekly QA rounds)
- Interpersonal Skills:
 - Complaints from patient/guest relations and to cancer program leadership
 - Complaints or compliments from PRC surveys
 - Complaints sent to human resources
- Professionalism:
 - Attendance at cancer program and division meetings
 - Attendance at multidisciplinary tumor conferences
- Systems Based Practice: compliance with national guidelines (NCCN – reviewed at weekly QA; via pathways – pending).

Department of Surgery:

- Premier Focus Report:
 - Mortality
 - Complications/patient safety indicators
 - Length-of-stay
 - 30 day readmissions
 - Cost per case (list on the report but excluded for OPPE)
 - Volume of procedures
 - Resource utilization.
- Interpersonal Skills:
 - Complaints from patients/guest relations
 - Complaints from staff
 - Complaints or compliments from surveys.

- Professionalism:
 - Participation in hospital administration and education activities
 - Attendance at faculty meetings and department committee meetings
 - 07:30 start-time delays.

For Advanced Practitioners (chart reviews):

Acute Care Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: General knowledge acute care surgical patients management in the pre-op and post-operative setting.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Breast Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of breast surgical procedures, pre-op and post-operative care.

Ortho-Trauma Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: General knowledge of acute care surgical patient management in the pre-op and post-operative setting.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Pediatric Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of the pediatric surgery patient, including pre-op and post-operative care.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Plastic Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of the plastic surgical procedure, pre-op and post-operative care.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Robotic Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of minimally invasive surgical procedures, pre-op and post-operative care of the minimally invasive surgical patient.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Surgical Oncology

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of the oncological surgical procedures, pre-op and post-operative care.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Thoracic Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of thoracic surgical patients pre-op and post-operative care.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Trauma Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge in the management of multi-injured patient; including resuscitation, non-operative management, and post-operative management and pain control.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Transplant Surgery

- Patient Care: Acquire accurate and relevant history from patients in a customized and prioritized fashion.
- Medical Knowledge: Knowledge of pre-op and post-operative surgical management of the transplant patient.
- Interpersonal and Communication Skills: Active information exchange with attending physicians, subspecialists, and ancillary services.

Appendix E

Baystate Health Ongoing Professional Practice Evaluation (OPPE) Report Response Form – Mary Lane Hospital

Department Chair

Name of Provider: _____

OPPE Effective: 06/01/16

To Be Completed By the Chairman

(Pursuant to The Joint Commission, this section must be completed and needs to address the Ongoing professional practice evaluation (OPPE) of the individual practitioner):

Based upon a complete review of clinical indicators and other pertinent OPPE data, and with particular emphasis on education/training, experience, current competency and health status, I recommend the above named practitioner is capable of performing medical staff duties and is competent of performing each specific clinical privilege requested with the following exceptions (if any):

Satisfactory Unsatisfactory Comments

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 at the end of life:

☐ ☐

Medical 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:

☐ ☐

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 the 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 healthcare is provided, and the ability to apply this knowledge to improve and optimize health care:

☐ ☐

RECOMMENDATION:

_____ Approve
 _____ Approve with conditions/modifications: _____
 _____ Practitioner notified by Chairman of conditions/modifications on _____ Date
 _____ Low/No Volume (Need More Data)

REQUIRED SIGNATURE:

Chairman Signature: _____ Date: _____

Appendix F

Centura Quality Professional Practice and Peer Review



POLICY TITLE: Quality Professional Practice and Peer Review (Centura)	
CATEGORY: Acute Care Facilities, Medical Staff	ORIGINATION DATE: 08/18/2020
SUB-CATEGORY: Medical Staff	PUBLICATION DATE: 09/21/2020
APPLICABLE FACILITIES: Avista Adventist Hospital, Bob Wilson Memorial Hospital, Castle Rock Adventist Hospital, Littleton Adventist Hospital, Longmont United Hospital, Mercy Regional Medical Center, Parker Adventist Hospital, Penrose St. Francis Health Services, Porter Adventist Hospital, St. Anthony Hospital, St. Anthony North Health Campus, St. Catherine Hospital, St. Mary Corwin Medical Center, St. Thomas More Hospital, Summit Medical Center	

SCOPE

This policy applies to all Physicians (MDs/DOs, Dentists, Podiatrists) and Advanced Practice Providers (APPs) granted clinical privileges at Centura hospitals. This policy and the practices of the Medical Staff are consistent with the Colorado State Peer Review Statute and Kansas State Peer Review Statute.

PURPOSE

This policy defines the organizational structure, including the processes and procedures, of the Medical Staff by which it fulfills its Board of Directors (BOD)-delegated responsibility to ensure the quality and safety of the medical care provided by privileged providers, i.e. physicians and APPs. This responsibility includes ongoing and focused professional practice evaluations and other performance improvement functions.

The Medical Executive Committee (MEC) has delegated these responsibilities to the multi-specialty Quality, Professional Practice, and Peer Review Committee (QPRC). Quality, safety and professional practice oversight will be conducted in alignment with High Reliability Organization (HRO) principles and with the promotion of a Just Culture. In contrast, the MEC has delegated Initial Focused Professional Practice Evaluation to the Credentials Committee.

POLICY

1. **Quality, Professional Practice, and Peer Review Committee (QPRC):**
 - a. The QPRC is responsible for Professional Practice Evaluation as delegated by the MEC. In turn, the QPRC may authorize other medical staff committees, departments, or sections to perform peer review activities. Summary reports of such activities must be submitted to the QPRC at least quarterly.
 - b. The QPRC will provide its own summary reports to the MEC and BOD at least quarterly
 - c. The respective Medical Staff's may elect to operate a joint peer review committee between hospitals.
 - d. **Membership and voting rights:** A quorum will consist of at least three (3) voting members.
 - 1) QPRC Chair (Physician) (voting)
 - 2) Physician members, at least three (3), from a cross-section of specialties (voting)
 - 3) APP member(s), one (1) or two (2) members, of which one would preferably be a nurse practitioner (voting)
 - 4) Chief Medical Officer/Director of Medical Affairs (CMO/DMA), Chief Nursing Officer or senior nurse leader designee and other senior executive members as invited (non-voting)

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- 5) Quality & Patient Safety Director (non-voting)
- 6) Peer Review Coordinator (non-voting)
- 7) Medical Staff Services representative (non-voting)

e. **Appointment of Committee Chair and Members:** The committee chair and members will be appointed by the President of the Medical Staff in consultation with the MEC.

1. Professional Practice Evaluation for privileged physicians and APPs will use an objective peer review process, including focused and ongoing professional practice evaluations (FPPE and OPPE, respectively) and case reviews. The goal is to partner with physicians and APPs to accomplish the following:
 - a. deliver reliable, safe, high quality care;
 - b. ensure competency and professionalism;
 - c. support a fair “Just Culture”;
 - d. become a sustainable High Reliability Organization; and
 - e. promote performance improvement with transparency, timely data, and recognition of excellence as well as opportunities for improvement.
2. Professional Practice Evaluation activities, including all communications, data, information and records, are privileged and confidential pursuant to Colorado Professional Review Act (CPRA), Kansas Peer Review Statute, as applicable, and the Medical Staff bylaws pertaining to confidentiality and non-discoverability. These privileged and confidential protections are specifically extended to other medical staff department, section, committee, director, and physician/APP reviews that have been delegated by or on the behalf of the QPRC.
3. All Physicians and APPs are obligated to participate in the Professional Practice Evaluation processes pursuant to the Medical Staff Credentials Policy and the Policy on Advanced Practice Providers and Dependent Practitioners.

PROCEDURE:

A. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

FPPE will be a time-limited process for the Medical Staff to evaluate a Physician’s/APP’s general competence or for specific privileges.

1. **Initial FPPE:** when a Physician/APP has not yet demonstrated competence for performing the requested privileges at the Centura hospital, i.e. initial appointment, request for additional privileges, or privileges that have not been exercised for an extended period.
 - a. Initial FPPE is the purview and responsibility of the Medical Staff Credentials Committee.
 - b. Initial FPPE plans will include the type and number of reviews as well as the specific time period in which the reviews will be completed.
 - c. Medical Staff department chairs, section chiefs and individual Physicians/APPs will assist in establishing and monitoring the review requirements, as requested.
 - d. Reviews may include, but not be limited to, any or all the following:
 - 1) Retrospective case review;
 - 2) Direct observation;
 - 3) Proctoring; or
 - 4) Specific training requirements, e.g. course, continuing medical education (CME)
 - e. Initial FPPE reviews will include at least three (3) reviews of the core privileges and one (1) review for each special privilege, unless the Credentials Committee deems a review for a specific special privilege not necessary given the other demonstrated competencies.

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- f. Medical Staff Services (MSS) will track the completion of the required reviews. The initial FPPE period may be extended, at the discretion of the Credentials Committee Chair, if there has been insufficient volume of activity for review.
2. **For Cause FPPE:** when questions arise about a privileged Physician's/APP's ability to provide optimal, safe, high quality patient care. Examples include the following:
 - Individual or trend of case review(s) with potentially preventable harm or negative outcomes;
 - Rate indicator or rule violation concerns; and
 - OPPE concerns.
- a. For Cause FPPE is the purview and responsibility of the QPRC.
- b. Medical Staff department chairs, section chiefs and individual Physicians/APPs will assist in developing and monitoring FPPE plans, as requested on behalf of the QPRC.
- c. For Cause FPPE may include, but not be limited to, any or all the following:
 - 1) Retrospective case review;
 - 2) Direct observation;
 - 3) Voluntary education;
 - 4) Rate or rule compliance tracking;
 - 5) External peer review; or
 - 6) Referral for voluntary psychological or professional competency review
- d. For Cause FPPE reviews will be approved by the QPRC and will specify the review details as well as the specific time period in which the review will be completed. For Cause FPPE that are voluntary will be summarized and shared with the MEC. Involuntary For Cause FPPE will require approval by the MEC.
- e. For Cause FPPE may be utilized, when appropriate, to assess a privileged Physician's/APP's quality of care or conduct when a determination has not been made whether corrective action and/or an investigation is warranted. However, the "For Cause FPPE" would still be considered synonymous with an "investigation" and any resignation while under this type of "For Cause FPPE" should result in a report to the National Practitioner Databank (NPDB).
- f. The Peer Review Coordinator (PRC), in collaboration with the Medical Staff Services, will track the completion of the required reviews.
3. Failure of a Physician/APP to cooperate with these provisions may result in corrective action as delineated in the Medical Staff Credentials Policy.
- B. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**
 1. OPPE will provide a process for evaluating a Physicians'/APP's professional practice every six (6) to eight (8) months, but no less than three (3) times during any twenty-four (24) month reappointment cycle. The process is intended to monitor quality of care, identify exemplary performance, and recognize opportunities for improvement.
 2. OPPE Reports
 - a. The OPPE content will incorporate general competencies modeled after those outlined by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS):
 - 1) Patient Care;
 - 2) Systems-Based Practice;
 - 3) Medical Knowledge;
 - 4) Interpersonal and Communication Skills;
 - 5) Professionalism; and

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- 6) Practice-Based Learning and Improvement
- b. Data used to compile the OPPE reports may include, but will not limited to, the following:
 - 1) patient care volume;
 - 2) patient satisfaction;
 - 3) clinical quality indicators defined by the Department;
 - 4) individual case review results;
 - 5) rule indicators;
 - 6) rate indicators; and
 - 7) significant citizenship events (positive and negative), i.e. appreciation from patients and staff, citizenship committee reports.
- c. The OPPE reports will be maintained by Medical Staff Services for at least two (2) years
3. OPPE Review: Individual and section OPPE reports will be reviewed and approved by the QPRC, with assistance from department chairs and section chiefs, as requested. Approval may be documented in the QPRC minutes.
4. Informing the reappointment process: The QPRC will share significant concerns with the Credentials Committee to help inform the reappointment process. The QPRC may collaborate with the Credentials Committee to formulate a For Cause FPPE tied to the reappointment, e.g. monitoring compliance with rule indicators for a defined period.
5. Escalation of or plans to address significant quality concerns will be pursuant to the Medical Staff Credentials Policy
- C. INDICATORS FOR REFERRAL:** ([Appendix A](#))
 1. Indicators for Referral is a set of measures that may trigger a referral to the QPRC to screen for possible quality of care concern. The indicators may be general, i.e. applicable to most physicians/APPs or may be specialty specific.
 2. Development and approval: The development and maintenance of the Indicators for Referral will be a Centura enterprise coordinated process overseen by the CMOs/DMA's, with review and input from each hospital's QPRC. The individual hospital's QPRC will be responsible for including the appropriate department chairs, section chiefs or physician/APP representatives for specialty specific indicators.

The indicators will be categorized as triggers for the following:

- a. Case review;
- b. Rate; or
- c. Rule compliance

The formal list of Indicators for Referral will be standardized across all hospitals to allow consistency of evaluation and support from the system. On an annual basis, each hospital's MEC and/or QPRC's should strive to review and adopt the indicators recommended by Centura Health or Indicators can be selected from the system developed indicator list.

3. Maintenance: As it is recognized that the individual indicators and their categorization may require revision throughout the year, the system-wide list may be updated by a representative group of CMOs/DMA's and PRCs. Any such revision to the system-wide list will require consent by the President of the Medical Staff and the CMO/DMA at all hospitals. An example would be a case review indicator that can now be addressed as a rate indicator. Hospital QPRCs may trial additions of new indicators and indicator categorization until the measures can be addressed as a system.

D. CASE REVIEWS: ([Appendix B: Case Review Flow Diagram](#))

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1. Individual Case Reviews should be limited to those cases that are not better assessed by rule or rate indicators, i.e. significant events, unusual or concerning trend, which require detailed medical record assessment and care evaluation. Cases primarily involving professional conduct may be referred to the appropriate Medical Staff leader or committee to review and address according to the hospital's policy for citizenship or code of conduct.
2. Screen and initial peer review assignment: The PRC will screen referrals. If appropriate for peer review, the PRC and QPRC chair will assign the review to a physician/APP. For the initial review, as peers, only physicians will review care concerns involving physicians, and APPs will review care concerns involving APPs. The reviewer may not necessarily be a member of the QPRC depending on the expertise needed. Any reviewer potential conflict of interest should be declared and addressed by the QPRC chair. All reviews should be requested on behalf of the QPRC and conducted in a confidential manner to maintain the protections of the state peer review statutes. Correspondence should include the following confidentiality statement:
"Confidential and privileged information subject to the quality management program, patient safety, professional review, and/or attorney/client privileges and protections pursuant to State and federal law. Do not copy, distribute, or re-disclose."
3. Initial Peer Review:
 - a. The PRC will be responsible for creating a Situation, Background, Assessment, and Recommendation of questions to be addressed (SBAR) summary of key pertinent facts from the initial referral and review of the medical record. The peer review SBAR will be given to the Physician/APP to help facilitate the review.
 - b. If initial review reveals no concerns, and QPRC chair reviews and agrees with the rationale, the case should be referred to the QPRC for the consent agenda.
 - c. If concerns are raised, the reviewer will discuss the case with the QPRC Chair and a letter of inquiry (be email) with clarifying questions will be sent, on behalf of the QPRC or QPRC Chair, to the physician/APP under review.
 - d. The Physician/APP will be given fourteen (14) days from the date of the email, if there are no mitigating factors, to provide a written response (e-mail) to the QPRC.
 - e. If a written response is not received in the required timeframe, the QPRC may complete its evaluation without the Physician's/APP's additional information. The QPRC may also invite Physicians/APPs to appear in person, in lieu of or in addition to a written response.
4. QPRC Case Reviews: The QPRC will approve the consent agenda including all cases with "no concern", unless the members of the QPRC request that a specific case be moved to the main agenda for further discussion. The QPRC will then review each case review with concerns or "no concern" pulled from the consent agenda. The QPRC will carefully consider the materials presented including the Physician's/APP's clarifying letter before making a final determination:
 - a. Exemplary care;
 - b. No improvement opportunity;
 - c. Minor improvement opportunity;
 - d. Moderate improvement opportunity; or
 - e. Major improvement opportunity.
5. **Safety Event Classification (SEC) and Coordination with Patient Safety** ([Appendix C](#)): Centura's journey to become a High Reliability Organization (HRO) and achieve zero preventable harm is dependent on the coordination between the Medical Staff and Hospital Quality Department to identify lessons learned from events of harm and near misses. These events represent opportunities to create an environment conducive to safe patient care. At the same time, the protections of peer review must be maintained.

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If when scoring case reviews, the QPRC determines that a deviation from Generally Accepted Practice (GAP) did occur, physician/APP related or not, and a serious, precursor or near miss safety event occurred, it will determine a SEC score. This score will be shared with the CMO/DMA and/or Patient Safety Officer. The information shared shall consist only of the SEC score without assignment of blame, i.e. hospital process, equipment, nursing or physician/APP related.

6. When an opportunity for improvement is identified, the QPRC will consider the Just Culture Algorithm ([Appendix D](#)) in making its determination and require one or more of the following actions, using the continuum of progressive steps ([Appendix E](#)):
 - a. Acknowledgment letter of self-directed learning or intervention;
 - b. Letter of guidance, counsel, warning or reprimand;
 - c. Educational letter;
 - d. Collegial interventions, which may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training and education;
 - e. Performance Improvement Plan (PIP); may include, but not be limited to one or more of the following:
 - 1) retrospective chart review;
 - 2) concurrent monitoring;
 - 3) second opinions or consultations;
 - 4) proctoring;
 - 5) structured education or CME; and
 - 6) formal psychological and competency assessment and/or training program; or* PIPs may be shared with the Department Chair and Practice Leadership as warranted to facilitate successful completion and ensure patient safety
7. Any Performance Improvement Plan (PIP) that is non-voluntary, involves modification of privileges, provides grounds for a hearing, or requires reporting to the Board of Medical Examiners or National Practitioner Data Bank will require referral and approval by the MEC and will be addressed according to the Medical Staff Credentials Policy
8. The reviews, supporting documentation and final determinations will be tracked in the Centura-approved peer review tool.
9. Pertinent information regarding Professional Practice Evaluation activities will be maintained in the Physician's/APP's Quality file and incorporated into the evaluation of current competence during the reappointment process.

E. RULE AND RATE INDICATORS

1. **Rule Violations (System/Documentation Issues).** Rule violations occur when a required processes or documentation is not performed. As the compliance is binary, i.e. yes or no, the PRC or QPRC Chair will determine if a rule violation occurred without further QPRC discussion. A letter of guidance or reprimand will be sent to the Physician/APP. Repeated rule violations will be escalated to QPRC discussion for consideration of progressive steps.
2. **Rates (Frequency/Statistical analysis).** Rates of adverse clinical outcomes are utilized when timely, reliable, pertinent and more appropriate than case reviews. Appropriate rates include known complications or situations not entirely under the control of the Physician/APP such as readmission rates, post-operative hemorrhage or venous thromboembolism. No specific patient records are evaluated initially, unless warranted. As possible and applicable, rates will be provided with the rates of the section, hospital, Centura system, or national rates or benchmarks

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to allow comparison and screen for potential concerning variations. The intent of rate monitoring is to identify opportunities for constructive intervention to achieve optimal outcomes and avoid future significant adverse outcomes.

3. Notification and Escalation: A letter of inquiry/guidance will be sent to the Physician/APP when a rule violation or significant variation from an expected rate occurs. Repeated rule violations (as defined in Appendix A) or rate variations that do not improve or are of particularly serious concern will warrant a more thorough review of the practitioner's care by the QPRC.

F. External Case Reviews

1. External case review will involve the use of a Physician/APP consultant with similar training who is not a member of the Medical/APP staff at the respective hospital.
2. An external peer review will be conducted when the QPRC or MEC has determined one or more of the following:
 - a. the Medical Staff does not possess adequate the required expertise to evaluate the concerns;
 - b. the only Physicians/APPs on staff with the specialty expertise have or would be perceived to have a significant conflict of interest; or
 - c. no determination can be made based on internal conflicting assessments.
3. External review may be requested by the Physician/APP under review, the QPRC, the Medical Staff Leadership (Medical Staff President, Department Chair) or the Hospital's Senior Leadership (CEO, CMO/DMA or CNO). External Case review requests must be approved by one of the following:
 - a. the MEC;
 - b. the QPRC; or
 - c. a consensus of the CMO/DMA, the Medical Staff President, and the Chair of the QPRC.
4. External review may be completed by one of the following methods:
 - a. Centura External Review: This is the preferred method for external review and involves referral to a credentialed Physician/APP at another Centura facility, who is contracted with Centura to perform case reviews.
 - 1) Referral and coordination will be managed by the hospital PRCs, and
 - 2) The referring Centura hospital will provide the reimbursement for the Centura physician/APP reviewer at the contracted rate.
 - b. Professional External Review: This method should be limited to reviews that cannot otherwise be addressed by a Centura External Review, i.e. conflict of interest, lack of expertise, or there is concern that the outcome of the review may invoke a fair hearing or legal actions. Professional External Review will be coordinated only with Centura contracted companies.
5. Role of the PRC:
 - a. The PRC will initiate the appropriate Centura-approved contract with the external reviewer prior to releasing any medical records. A copy of the medical records will be prepared and sent in a manner that is HIPPA compliant utilize certified mail or secure electronic communication;
 - b. The PRC will coordinate the exchange of information and payments with the PRC of external reviewer for Centura External Reviews or the designated coordinator for the professional external review company.
 - c. The PRC will provide the external reviewer written instructions including but not limited to:
 - 1) The nature of the concerns, the name of the physician/APP under review; and
 - 2) the timeframe for expected review completion and provision of the report.
6. Final Determination: Upon receipt, the PRC will provide the external review to the hospital's QPRC

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Chair, President of the Medical Staff and the CMO/DMA. It will then be shared with the QPRC for its usual review and determination, in substitution for an internal peer review. The final determination of quality of care is the purview of the local QPRC.

G. QPRC Referrals:

1. **MEC:** The QPRC may refer concerns about a case, trend of cases, repeated rule violations or significant rate variations directly to MEC at any time when it determines that immediate action by the MEC may be necessary to ensure patient or staff safety.
2. **Risk Manager:** The QPRC may refer concerns to the Risk Manager if an identified issue is believed to potentially expose the Physician/APP and/or Hospital to risk of liability.
3. **Medical Staff Departments, Sections, Committees or Practices:** The QPRC may refer concerns of process, technique or practice to the appropriate Medical Staff Department, Section, Committee or Practice if it believes such a referral will be more effective and provide an improvement opportunity for the members of that group, i.e. instructional or education.
4. **Centura Health Physician Group (CHPG) employed Physicians/APPs:** The CHPG group has its own professional review committee protected under Colorado Peer Review Statue 12-36.5-105 and Kansas Peer Review Statute (Chapter 65. Public Health § 65-4915). If sharing of significant concerns with the CHPG professional review committee or its leaders is warranted, peer review protections are maintained.
 - a. Hospital/Practice care overlap: If a concern is raised with significant overlap between the hospital setting and the CHPG practice, the CMO/DMA, QPRC Chair and the CHPG leadership will determine which body is most appropriate to conduct the review, in order to avoid two separate reviews of the same incident. In such cases, the reviewing body will share its final determination with the other non-reviewing body.
 - b. Significant care concerns, For Cause FPPE, and Performance Improvement Plans may be shared with the local CHPG leadership, as appropriate, to ensure patient safety and to improve the effectiveness of the constructive evaluations and/or interventions.

H. Peer Review in Medical Staff Departments, Sections, Committees or by Medical Directors;

1. **Delegation:** Medical Staff Departments, Sections, Committees or Medical Directors may be delegated the responsibility to perform peer review functions on a regular or an ad hoc basis. This peer review activity is performed on the behalf of the QPRC and is protected under Colorado Peer Review Statue 12-36.5-105 and Kansas Peer Review Statute (Chapter 65. Public Health § 65-4915). Examples include Trauma Committee, Emergency, Pathology, and Radiology peer review, as well as ad hoc requests for Medical Directors or specific Medical Staff physicians/APPs specifically requested to perform initial review of the quality of care concerns raised by complaints and grievances. Correspondence of such reviews should include statements of confidentiality.
2. **Processes and Scoring:** The reviews delegated to Medical Staff bodies should use the same processes and scoring outlined in this policy.
3. **Quarterly Summary Reports:** Medical Staff Departments, Sections and Committees that have been delegated regular professional review activities, should provide quarterly summaries of their review activities to the QPRC. Summaries should include, but not be limited to the following:
 - a. # Cases reviewed
 - b. Case review determinations:
 - 1) # Exemplary Care;
 - 2) # No concerns;
 - 3) # Minor Improvement Opportunity;

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- 4) # Moderate Improvement Opportunity;
- 5) # Major Improvement Opportunity;
- c. Summary of significant system, process, or individual concerns and improvement activities
- I. **Educational case or M&M/CME reviews** performed by Medical Staff are not considered peer review activities and are not required to follow the procedures in this policy. They are, however, considered hospital quality management activities for the purposes of confidentiality and discoverability in legal proceedings. These educational reviews are an integral part of performance improvement activities.
- J. **Amendments:** As it is recognized for the purpose of adopting best practices and lessons learned throughout the year, amendments to this policy may be proposed and adopted if unanimously approved by the individual Presidents of the Medical Staff and the CMO/DMA at all of the hospitals. Annual approval by the hospital Medical Executive Committees is recommended on an annual basis.

DEFINITIONS

REFERENCES AND SOURCES OF EVIDENCE

- Colo. Rev. Stat. §12-20-204
- Kansas Public Health § 65-4915

REVIEW/APPROVAL SUMMARY

REVIEW/REVISION DATES PRIOR TO POLICY TECH: N/A	
COMMENTS:	
LAST REVIEW DATE: 09/21/2020	NEXT REVIEW DATE: 09/21/2023
APPROVAL BODY(IES): Centura CMO Medical Council, Enterprise Policy Administrator	APPROVAL DATE: 09/21/2020

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Appendix A: Indicators for Referral

The Indicators for Referral are a set of events that trigger a possible peer review. These indicators are reviewed annually by the Medical Staff and may be revised in the interim by a Medical Staff approved process. The listed indicators should be considered for inclusion in OPPE and other professional practice evaluations. However, individual indicators may not be appropriate for some specialties, reliable in their current state and with the necessary attribution for inclusion for the time-being. These are recommendations and not requirements.

A. General Indicators, i.e. applicable to all specialties

1. Case Review:

- a. Sentinel events
- b. Questionable care or deviation from Generally Accepted Practice (GAP)
- c. Missed or significantly delayed diagnosis
- d. Undesirable trend or practice pattern
- e. Unplanned transfer to a higher level of care
- e. Unplanned readmissions within 30 days
- f. Failure to respond in a timely fashion
- g. Unexpected death, i.e. death with low severity-adjusted level, e.g.1 or 2
 - 1) Exclusion considerations:
 - i. admission for palliative care/hospice care;
 - 2) Inclusion criteria for mod-high severity-adjusted level:
 - i. potential delay in diagnosis or treatment;
 - ii. unplanned removal/injury of an organ during a procedure;
 - iii. unintended lack of treatment of significant metabolic or hemodynamic abnormalities;
 - iv. complaints and/or grievances concerning quality of care;
 - v. Physician/APP, committee, administrative, nursing or staff referrals;
 - vi. notices of lawsuits or claims involving Physicians/APPs.

2. Rule Indicators: (# in parenthesis indicates threshold for escalation to QPRC for consideration of progressive steps)

- a. non-compliance with Medical Staff Bylaws, Policies, Guidelines or Protocols (3);
- b. Inadequate or missing required documentation:
 - 1) History & Physical or History & Physical procedural update (3)
 - 2) Consultation (3)
 - 3) Progress Note (3)
 - 4) Operative Note (3)
 - 5) Discharge Summary (3)

3. Rate Indicators:

- a. Deviations from appropriate length of stay and utilization of resources
- b. Patient Safety Indicators:
 - 1) PSI-02: Death Rate in Low-Mortality Diagnosis Related Groups (DRGs)
 - 2) PSI-06: Iatrogenic Pneumothorax Rate
 - 3) PSI-07: Central Venous Catheter-related Blood Stream Infection Rate
 - 4) PSI-08: In Hospital Fall with Hip Fracture Rate

B. Emergency Department Indicators

1. Case Review:

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- a. Unscheduled returns to ED within 48 hours

C. Surgical Section Indicators

- 1. Case Review:
 - a. Unplanned return to surgery within 30 days
- 2. Rule Indicators:
 - a. History & Physical not performed within 30 days, no H&P update completed
 - b. Surgical/Procedure Consent not completed and signed prior to Time Out
 - c. Time-out not performed
- 3. Rate Indicators:
 - a. PSI-04: Death Rate among Surgical Inpatients with Serious Treatable Complications
 - b. PSI-05: Retained Surgical Item or Unretrieved Device Fragment Count
 - c. PSI-09: Perioperative Hemorrhage or Hematoma Rate
 - d. PSI-10: Postoperative Acute Kidney Injury Requiring Dialysis
 - e. PSI-11: Perioperative Respiratory Failure Rate
 - f. PSI-12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
 - g. PSI-13: Postoperative Sepsis Rate
 - h. PSI-14: Postoperative Wound Dehiscence Rate
 - i. PSI-15: Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate

D. Anesthesiology Section Indicators:

- 1. Case Review (as per General Indicators)
- 2. Rule Indicators: (as per General Indicators)
- 3. Rate Indicators:
 - a. PSI-11: Perioperative Respiratory Failure Rate

E. Ob/Gyn and Family Practice Section Indicators

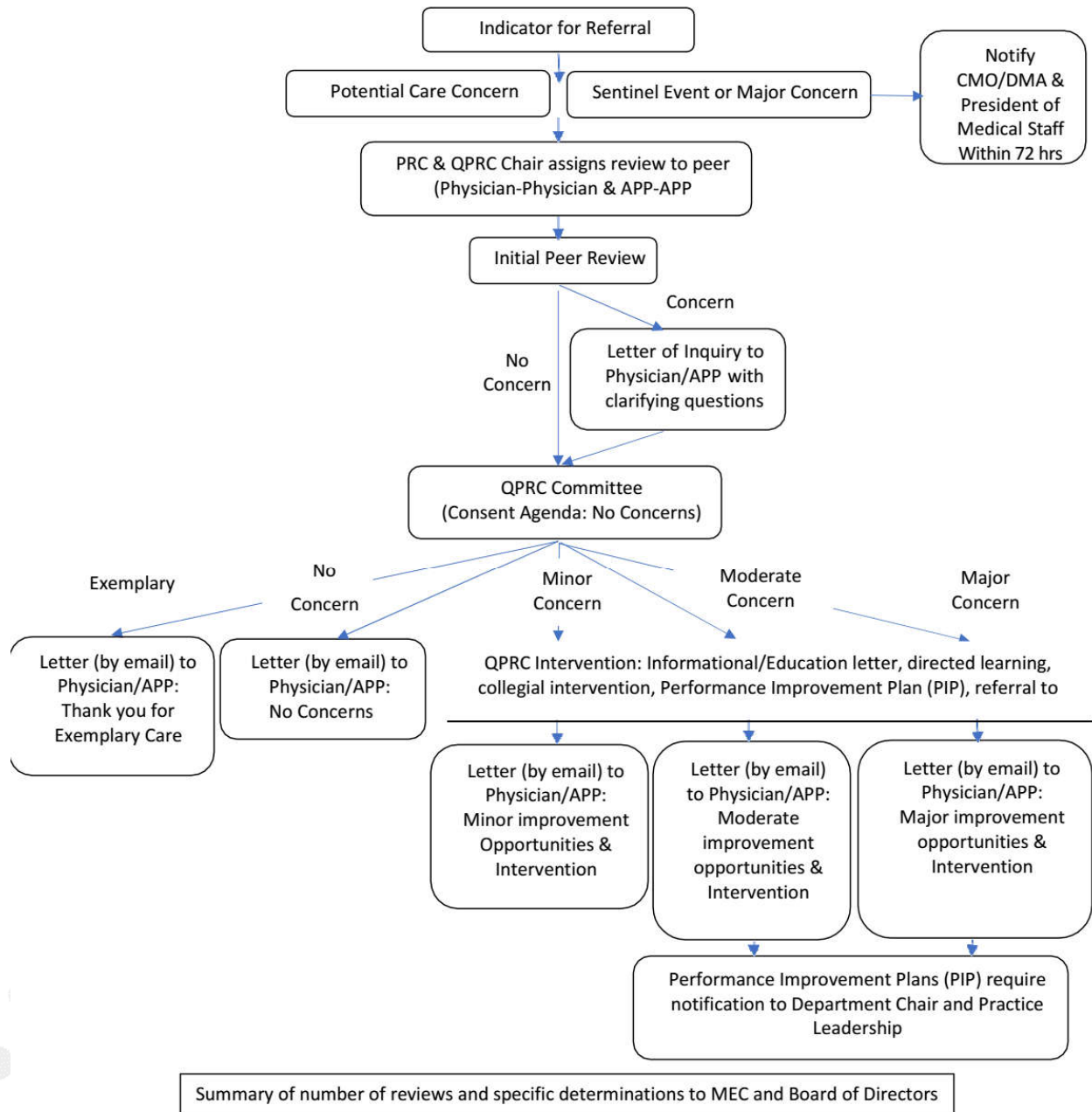
- 1. Case Review
 - a. postpartum return to delivery room or operating room for management;
 - b. delivery of an infant with birth weight less than 2500 grams or respiratory distress syndrome after a planned cesarean section or induction of labor;
 - c. Apgar score < 4 or less at five (5) minutes;
 - e. fetal demise.
- 2. Rule Indicators
 - a. Elective induction prior to 39 weeks gestation
- 3. Rate Indicators
 - a. PSI-17: Birth Trauma Rate – Injury to Neonate
 - b. PSI-18: Obstetric Trauma Rate – Vaginal Delivery with Instrument;
 - c. PSI-19: Obstetric Trauma Rate – Vaginal Delivery without Instrument

F. Radiology Section Indicators

- 1. Case Review
 - a. Significant reading or communication omission



Appendix B: Case Review Flow Diagram



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Appendix C: Safety Event Classification (SEC) (adapted from HPI/Press Ganey)

1) Deviation from Generally Accepted Performance Standards (GAPS): deviations are determined by comparing actual performance to expected performance in reference to both internal and external sources:

- a. Internal policies, procedures or protocols
- b. Nationally recognized best practices and standards of care
- c. Industry-imposed practice mandates and requirements
- d. Professional practice standards
- e. Objective review by other experts
- f. Organization's obligation to best protect patients from harm

2) Known Complication Test:

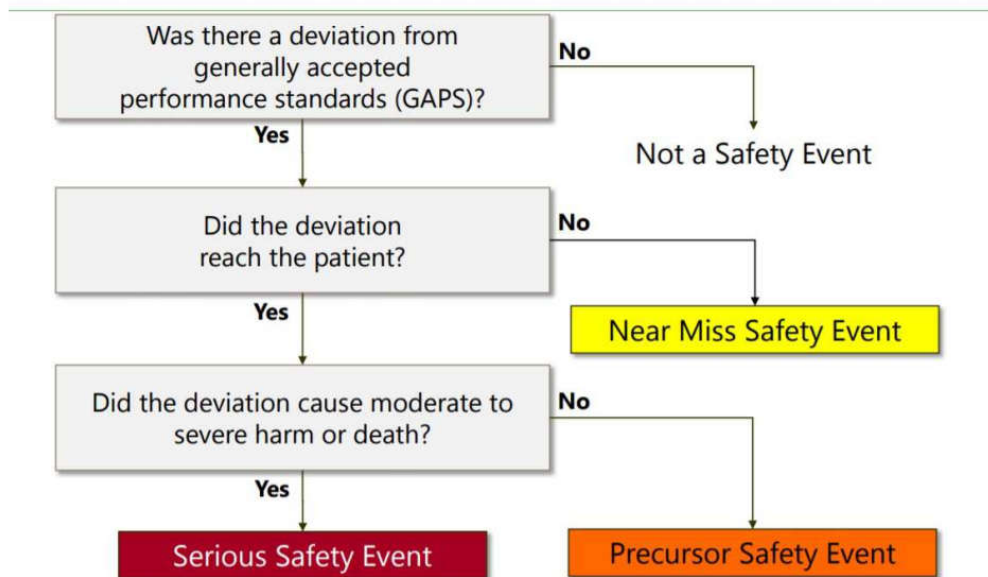
- a. Was the procedure, treatment or test appropriate and warranted?
- b. Was the complication a known risk, was it anticipated, and did the care team plan ahead to take steps to prevent it?
- c. Was the complication identified in a timely manner (i.e. at the time of occurrence)?
- d. Was the complication treated according to the standard of care and in a timely manner?

If the answer to All four (4) questions is "Yes", the event is considered a known complication and not a Safety Event.

If the answer to Any question is "No", the event is a Safety Event.

3) SEC Algorithm:

SEC Algorithm



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HPI Safety Event ClassificationSM (SEC) Levels of Harm
Safety Event classification applies if a deviation from Generally Accepted Performance Standards (GAPS) causes, or results in, the event

Code	Level of Harm	Description
SSE 1	Death	A deviation in GAPS resulting in death
SSE 2	Severe Permanent Harm	A deviation in GAPS resulting in critical, life-changing harm with no expected change in clinical status; includes events resulting in permanent loss of organ, limb, or vital physiologic or neurologic function Example - Wrong site procedure resulting in removal of healthy limb - Missed diagnosis of stroke resulting in permanent impairment - Uterine rupture resulting in loss of uterus - Anoxic brain injury resulting in permanent brain damage - Incorrect radiologic contrast dosing resulting in need for permanent dialysis A deviation in GAPS resulting in significant harm with no expected change in clinical condition yet not sufficiently severe to impact activities of daily living or business functioning; includes events that result in permanent reduction in physiologic reserve, disfigurement, and impaired or aided sense of function Examples - Incorrect radiology contrast dosing resulting in reduced renal function - Inadvertent injury to spleen during abdominal surgery requiring removal of the spleen - Delay in treatment of limb ischemia requiring fasciotomy that results in minimal loss of function but disfiguring scars - Inappropriate intra-arterial medication injection resulting in loss of a finger, other than the thumb or 2nd finger which may qualify the event as SSE 2 A deviation in GAPS resulting in critical, potentially life-threatening harm yet lasting for a limited time with no permanent residual; requires prolonged transfer to a higher level of care/monitoring, transfer to a higher level of care for a life-threatening condition, or an additional major surgery, procedure, or treatment to resolve the condition Examples - Induced condition that requires resuscitation - Unrecognized fluid overload that progresses to pulmonary edema requiring transfer to the ICU for treatment - Failure to diagnose respiratory insufficiency resulting in temporary intubation where earlier recognition of the condition would have avoided the intubation - Preventable fall with hip fracture that requires surgical repair - Retained object that requires return to the operating room
SSE 3	Moderate Permanent Harm	
SSE 4	Severe Temporary Harm	
SSE 5	Moderate Temporary Harm	A deviation in GAPS resulting in significant harm lasting for a limited time; requires a higher level of care/monitoring or an additional minor procedure or treatment to resolve the condition Examples - Failure to treat a low potassium level that results in an arrhythmia requiring administration of intravenous anti-arrhythmic drug, but with continued arrhythmia requiring extended monitoring and a higher intensity of care - Incorrect dose of dilaudid for pain resulting in over-sedation and requiring transfer to ICU for treatment and monitoring after narcosis was ineffective in treating - Failure to routinely assess IV site resulting in an infection at IV site or (septic phlebitis) requiring extensive surgical incision and drainage to resolve - Incision made on the right knee instead of the left knee during an arthroscopic knee replacement surgery

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HPI Safety Event ClassificationSM (SEC) Levels of Harm

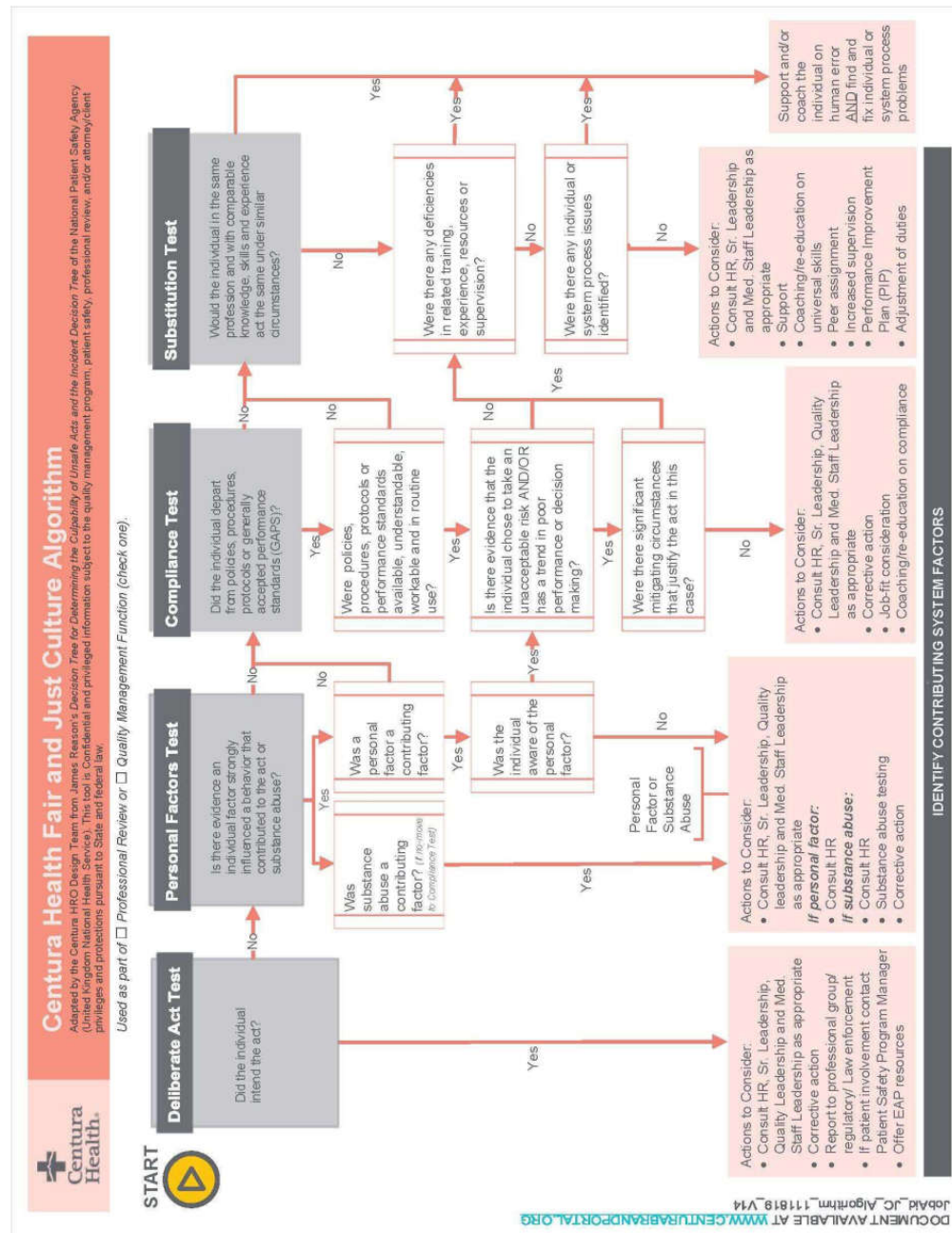
Safety Event classification applies if a deviation from Generally Accepted Performance Standards (GAPS) causes, or results in, the event

		Description	
Code	Level of Harm		
PSE 1	Minimal Permanent Harm	A deviation in GAPS resulting in minor harm with no expected change in clinical status; requires little or no intervention	
		Examples	
		- Inadequate protection of ulnar nerve during an operation resulting in numbness of 4th and 5th fingers - Excess radiation therapy resulting in skin color change in non-critical cosmetic area	
		A deviation in GAPS resulting in minor harm lasting for a limited time only; requires little or no intervention	
PSE 2	Minimal Temporary Harm	Examples	
		- Failure to assess IV site resulting in bruising or swelling - Retained sponge in vaginal cavity found and removed during office exam and resulting in no or minor infection - Administration of low dose insulin to a non-diabetic patient requiring only a glucose check and drink of orange juice - Incorrect dose of dilaudid for pain resulting in over-sedation and narcosis requiring immediate resolution - An anesthetic nerve block was performed on the right knee instead of the left knee in a scheduled knee replacement surgery before it was realized the wrong side had been anesthetized	
		A deviation in GAPS that reaches the patient yet without ability to determine the existence or fact of harm, yet harm may exist; includes events where the onset of harm may occur later in time	
		Example	
PSE 3	No Detectable Harm	- Procedure performed with un-sterile instruments with no detectable post-procedure complications or infection - Inappropriate technique resulting in losing coronary artery stent into systemic circulation with no evidence of limb or organ ischemia	
		A deviation in GAPS that reaches the patient yet results in no harm, with sufficient information available to determine that no harm occurred	
		Example	
		- Transfusion of blood intended for another patient yet of the correct blood type - Administration of an adult dose of vitamin K to a full term newborn infant with no resulting damage	
PSE 4	No Harm	A deviation in GAPS that passes through all error detection barriers and does not reach the patient because it is caught by chance or a barrier not designed into the system	
		Example	
		- Family member who reminds of a known medication allergy immediately before the medication is to be administered to the patient - Environment Services Associate points out the need to perform a time out prior to a bedside procedure resulting in awareness that the procedure was about to be performed on the incorrect limb - Food Services Associate notices pills in waste basket, thrown away by the patient, and alerts the patient's nurse who ensures medication administration	
		A deviation in GAPS that passes through early error detection barriers and is caught by a last strong error detection barrier designed into the system	
NME 1	Unplanned Barrier Catch	Example	
		- Medication error caught by nurse performing "5 Rights" prior to administration - Wrong patient brought to the OR and identified during the team time out	
		A deviation in GAPS that is caught by an early error detection barrier designed into the system's defense in depth	
		Example	
NME 2	Last Strong Barrier Catch	- Medication error identified when a contraindication alert fires in the pharmacy order entry system - During bedside shift change report, care team identifies that multiple IV lines in a complex ICU patient are not labeled and makes the correction to minimize risk of confusion	
		Example	
		A deviation in GAPS that is caught by an early error detection barrier designed into the system's defense in depth	
		Example	
NME 3	Early Barrier Catch	- Medication error identified when a contraindication alert fires in the pharmacy order entry system - During bedside shift change report, care team identifies that multiple IV lines in a complex ICU patient are not labeled and makes the correction to minimize risk of confusion	
		Example	
		A deviation in GAPS that is caught by an early error detection barrier designed into the system's defense in depth	
		Example	

HPI SEC Levels of Harm
Revision 1, May 2009
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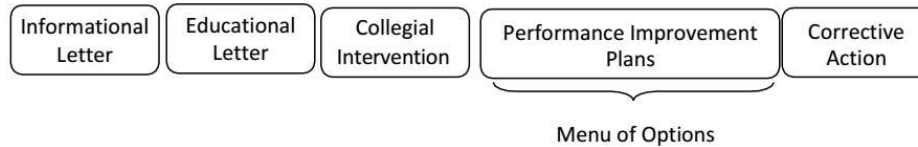
Appendix D: Just Culture Algorithm



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Appendix E: Spectrum of Potential Steps



Continuum of Progressive Steps:

- **Initial Collegial Leadership Efforts:**
 - Informal mentoring, coaching, or counseling
 - Sharing comparative data/variations from clinical practice (OPPE)
- **Acknowledgement Letters** to share issues and acknowledge self-directed improvement or intervention
- **Information Letters** to address minor, but still important, issues
- **Collegial Interventions**, planned and face-to-face, to more directly provide assistance
- **Performance Improvement Plans** for more significant issues/trends
- **Corrective Action**

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Appendix G

New Bridge Medical Center Wellness Committee Policy

	POLICY and PROCEDURE FOR DEPARTMENT SPECIFIC
<u>POLICY TITLE:</u>	WELLNESS COMMITTEE POLICY
<u>APPLIES TO:</u>	PHYSICIANS & ALLIED HEALTH PROFESSIONALS
<u>POLICY STATEMENT:</u>	The Wellness Committee ("Committee") is organized as a Medical Staff committee. The Committee is one tool available to the Medical Staff to ensure the health and wellness of members of the Medical Staff and allied health professionals. The Committee provides health education to practitioners, facilitates confidential diagnosis, treatment and rehabilitation of licensed practitioners who suffer from an impairing or potentially impairing condition, and monitors practitioners who are recovering from impairment. This policy is separate from and shall be implemented separately from medical staff disciplinary functions. Whenever it is determined a practitioner is unable to safely perform the privileges granted, the Chief Executive Officer and the President of the Medical & Dental Staff will take appropriate steps to eliminate any threat to patient safety. New Bridge Medical Center will comply with all state and/or federal reporting obligations when implementing this policy.
<u>DEFINITIONS:</u>	Practitioner(s) - shall include all physicians and all non-physician practitioners credentialed through the medical staff process.

PROCEDURE(S):

I. EDUCATION

The Wellness Committee will facilitate health and wellness education to practitioners.

II. CONFIDENTIALITY

- A. To the greatest extent reasonably possible under the circumstances, the activities of the Wellness Committee, including without limitation, investigations, interventions, reports and recommendations shall be conducted as part of the peer review and quality improvement functions of the medical staff and shall be treated confidentially.
- B. The Chair of the Committee may provide general updates to the New Bridge Medical Center Board of Directors, as requested from time to time. The information presented to the Board, shall remain privileged and confidential and shall only be used by the Board of Directors for the purpose of bettering the system of delivery of healthcare reducing patient morbidity and mortality and improving the quality of patient care.
- C. If requested, to the greatest extent reasonably possible under the circumstances, the identity of persons who report situations or behavior shall be kept confidential.

III. WELLNESS COMMITTEE COMPOSITION/AUTHORITY

- A. The Committee shall consist of, whenever possible:
 - 1. at least one (1) past or present President of the Medical & Dental Staff who is an active member of New Bridge Medical Center's medical staff, who will serve as Chairperson of the Wellness Committee;
 - 2. two (2) members of the active medical staff, one (1) of whom is a member of the psychiatry department;
 - 3. St. Luke's Chief Executive Officer ("CEO") or the CEO's designee;
 - 4. a nursing staff representative;
 - 5. a member of the Medical Staff Services Office;

6. the Director of Human Resources; and
 7. a physician with a previous history of impairment whose impairment has been successfully treated (if feasible); and
 8. Other members of the Medical Staff mutually selected by the President of the Medical & Dental Staff and the Chief Executive Officer so the Committee includes at least five (5) physician members.
 9. Other credentialed practitioners may also be invited to serve on the Committee.
- B. The Wellness Committee shall have the authority to perform the duties described in this Policy.
- C. The Committee shall meet as needed, as directed by the Chair or designee, and maintain such records of its proceedings as it deems advisable. The Committee reports on its activities to the Medical Executive Committee on a monthly basis using the Physician Monitoring Update form. The Physician Monitoring Update form shall also be routed to the Chief Executive Office and shall be made available to the New Bridge Medical Center's Board of Directors upon request.

IV. CONFLICT OF INTEREST

- A. If a Committee member is involved in the documented concern, that member will not be present for Committee discussion except to provide information as requested by the Committee.
- B. If the Wellness Committee Chair is involved in the documented concern, the Wellness Committee will select another Committee member as acting Chair.

V. FUNCTION

- A. The Committee is advisory and educational in nature, and not a substitute for a personal physician or a disciplinary body.
- B. The Committee provides recommendations to the MEC which assist in identifying, and contacting practitioners who have become professionally impaired in varying degrees because of drug dependence including alcoholism or because of mental, physical or aging problems.
- C. The Committee is available to support practitioners' efforts to rehabilitate.

- D. The Committee identifies and coordinates programs to prevent substance dependence.
- E. The Committee Chair shall notify the President of the Medical & Dental Staff, the impaired practitioner's department chairperson and Chief Executive Officer when any Committee member feels a practitioner's actions could endanger patients. The existence of the Wellness Committee does not negate the department chairperson's duty to monitor, intervene and report when a practitioner's actions could endanger patients, if applicable for clinical performance within that department chairperson's clinical service.

VI. REFERRAL AND SELF-REFERRAL

- A. Practitioners are encouraged to self-refer for appropriate diagnosis, treatment, and rehabilitation whenever they have, or are concerned they may have, an illness or condition which may impair their ability to safely perform the privileges granted by New Bridge Medical Center. Such self-referral may be to either medical staff leaders or to other internal or external resources such as the New Jersey State Board of Medicine/Professional Assistance Program of New Jersey/etc.).
- B. Practitioners and others are encouraged to refer to the Wellness Committee any situation, suspicion, or concern they have that another practitioner has or may have an illness or condition which may adversely affect the referred individual's ability to safely perform the privileges at New Bridge Medical Center.
- C. Referrals shall include, but are not limited to, situations involving unsafe treatment, physical impairment, possible drug or alcohol abuse, disruptive behavior, and emotional illness.
- D. Referrals identified in this policy are intended to be in addition to, and not in lieu of, any other incident or problem reporting systems at New Bridge Medical Center.

VII. REPORTING

- A. Complaints and concerns should be reported to the Chief Executive Officer and the President of the Medical & Dental Staff.
- B. If a practitioner is not involved, the concern/complaint will be referred to the appropriate New Bridge Medical Center representative for follow up.
- C. Unsubstantiated complaints will be dismissed.

- D. Substantiated complaints will be addressed by the Chief Executive Officer and the President of the Medical & Dental Staff, or their designees, and others as needed, in accordance with applicable policies, such as the Medical Staff Code of Conduct. The Committee will be informed of complaints related to the functions of the Wellness Committee.

VIII. REVIEWING COMPLAINTS

- A. The Chair of the Wellness Committee reviews concerns and complaints related to practitioner wellness in cooperation with the Chief Executive Officer and the President of the Medical & Dental Staff. Reviewing concerns includes, at a minimum, contacting the complaining party (ies), the involved practitioner and the appropriate Department Chairperson.
- B. If, after the initial meetings, there is sufficient information to warrant further investigation, the Chief Executive Officer, President of the Medical & Dental Staff, and Wellness Committee Chairman (or designee(s)):
 - 1. Will investigate concerns raised and any and all incidents.
 - a. Research and investigation may include, but is not limited to review of any and all documents or other materials relevant to the investigation, and interviews with any and all individuals involved in the incidents who may have information relevant to the investigation.
 - 2. Will meet informally with the practitioner involved.
 - a. This meeting does not constitute a hearing under the due process provisions of the Medical Staff Bylaws.
 - b. At this meeting health related questions may be asked as long as they are related to the performance of the individual's clinical privileges and responsibilities and are consistent with quality patient care or the operations of New Bridge Medical Center.
 - c. Documentation is placed in the Wellness Committee file and a summary is provided to the Credentials Committee, the Medical Executive Committee and/or the New Bridge Medical Center's Board at the time of the practitioner's reappointment, or earlier if requested.

3. May discuss with the individual whether a reasonable accommodation is necessary to ensure the practitioner competently and safely exercises his/her clinical privileges and carries out the duties and responsibilities of medical or allied health staff appointment.
4. May require the practitioner to take an alcohol/drug test to determine if the practitioner is currently using alcohol/drugs. If the practitioner refuses the evaluation, the Wellness Committee may recommend to Medical Executive Committee that a formal investigation and/or a precautionary suspension be initiated in accordance with the Medical Staff Bylaws.
5. May require that the individual undergo a complete examination so long as the exam is related to the performance of clinical privileges and responsibilities and is consistent with quality patient care or the operations of New Bridge Medical Center.
 - a. If the Wellness Committee requires the individual to undergo an examination, the evaluation shall be conducted by an outside person who may be selected by the practitioner from an approved list, or the Wellness Committee may defer to the resources of the Professional Assistance Program of New Jersey.
 - b. The practitioner must sign a release which allows the evaluating individual to report directly to the Wellness Committee.
 - c. If the practitioner refuses evaluation, the Wellness Committee may recommend to Medical Executive Committee that a formal investigation and/or a precautionary suspension be initiated in accordance with the Medical Staff Bylaws.

IX. REASONABLE ACCOMMODATIONS

Unless otherwise required by law or New Bridge Medical Center policies related to employed physicians, New Bridge Medical Center's administration and the Medical Executive Committee, in cooperation with outside resources as needed, determine:

- A. Whether a reasonable accommodation can be made necessary to ensure the practitioner would, with the reasonable accommodation, be able to competently and safely perform clinical privileges and carry out the duties and responsibilities of medical or allied health staff appointment.
- B. Whether a reasonable accommodation would create an undue hardship on New Bridge Medical Center, i.e., the accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of New Bridge Medical Center's operations or the provision of patient care.
- C. Whether the impairment constitutes a "direct threat" to the health or safety of the involved individual, patients, New Bridge Medical Center's employees, physicians or others within New Bridge Medical Center. A direct threat must involve a significant risk of substantial harm based upon medical analyses and/or other objective evidence.
 - 1. If the individual appears to pose a direct threat because of a disability, the Medical Executive Committee must also determine if it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation according to the Americans with Disabilities Act (ADA).
- D. If the Medical Executive Committee determines a reasonable accommodation can be made, New Bridge Medical Center, in cooperation with the Medical Executive Committee, shall attempt to develop a voluntary agreement with the individual, so long as that arrangement would neither constitute an undue hardship upon New Bridge Medical Center nor create a direct threat as described above. The Chief Executive Officer shall approve any agreement before it becomes final and effective.
- E. If the Medical Executive Committee determines there is no reasonable accommodation that can be made as described above, or if the Medical Executive Committee cannot reach a voluntary agreement with the individual, the Medical Executive Committee shall make a recommendation and report to New Bridge Medical Center's Board, through the President of the Medical & Dental Staff, as to appropriate actions to be taken in accordance with the Medical Staff Bylaws.

X. REHABILITATION

- A. If a determination is made to refer the practitioner for treatment, the Wellness Committee will assist the practitioner with contacting the Professional Assistance Program of New Jersey or another treatment facility.
- B. The practitioner may continue to practice, if it is deemed he/she can do so safely, while participating in a treatment program.

XI. REINSTATEMENT AND MONITORING GUIDELINES

- A. If a practitioner is suspended or takes a leave of absence for the purpose of treatment, that individual shall not be considered for reinstatement until it has been established, to New Bridge Medical Center's satisfaction, that the practitioner has successfully completed the program, and it is safe for the practitioner to return to work in a partial or full-time capacity. A letter from the physician director of the rehabilitation program where the practitioner was treated, which includes the following information, is required prior to reinstatement:
 - 1. A description of the program and services that the practitioner participated in.
 - 2. Whether the individual complied with all terms of the program.
 - 3. A description of any and all follow-up treatment, testing and monitoring recommendations.
 - 4. A description of ongoing monitoring that the practitioner has agreed to.
 - 5. A description of any and all impairments that may impact the practitioner's ability to safely exercise his/her clinical privileges and carryout his/her medical staff duties and responsibilities.
- B. In addition to the letter described above, if a practitioner will be participating in on-going treatment, monitoring or testing, New Bridge Medical Center must receive written assurances from the program and the practitioner that New Bridge Medical Center will receive regular written reports (at least quarterly) on the practitioner's treatment, continuing progress, compliance with the program, and ability to safely exercise his/her clinical privileges and carryout his/her Medical Staff duties and responsibilities.

- C. In considering reinstatement, New Bridge Medical Center and Medical Staff leadership must consider patient interest paramount. Refer to the Medical Staff Bylaws section for information on precautionary and summary suspension.
- D. If the practitioner fails to complete the required rehabilitation program, appropriate action will be taken with regard to membership and privileges as described in the Medical Staff Bylaws.

XII. MONITORING

- A. The Wellness Committee shall monitor a practitioner's compliance with ongoing treatment, monitoring and testing requirements. The Chair of the Committee shall immediately report incidents of noncompliance to the Chief Executive Officer and/or the President of the Medical & Dental Staff.
- B. The Department Chairperson and the Wellness Committee may recommend monitoring. This monitoring may consist of, but is not limited to, periodic discussions between the Department Chairperson, a member of the Wellness Committee, and the practitioner. The Wellness Committee member(s) present will submit a written record of monitoring meetings for placement in the practitioner's peer review file. This information will be available to the practitioner, the Department Chairperson, the Wellness Committee Chairman, the President of the Medical & Dental Staff and the Chief Executive Officer. Reports will also be presented to the Wellness Committee at scheduled meetings.
- C. The Wellness Committee shall provide periodic updates to the Credentials Committee and New Bridge Medical Center's Board of Directors regarding practitioners' compliance with monitoring activities.

XIII. PRACTITIONER RIGHTS

- A. Practitioners whose conduct is reviewed by the Wellness Committee have the right to:
 - 1. Be informed of any and all reports submitted. Copies of reports may be provided to the practitioner at the discretion of the Wellness Committee Chair and other Wellness Committee members involved. The purpose of this discretionary power is to protect, when necessary, the individual who submitted the report.
 - 2. Submit a written and/or verbal response to any reports.

3. Provide additional information from any source concerning any report.
4. Have all unsubstantiated reports and/or other documentation eliminated from any and all New Bridge Medical Center and/or Committee files.
5. Have all reports and/or documentation used and disclosed as described in this policy.

COMMITTEE APPROVALS:
DATES OF APPROVAL

<u>RELATED DOCUMENTS:</u>	
Credentials Committee	
Medical Executive Committee	
Board of Trustees	
<u>POLICY AUTHORIZED BY BOARD OF TRUSTEES:</u>	_____ President/CEO New Bridge Medical Center _____

Appendix H

ACGME Core Competencies²⁶

ACGME Core Competencies measure a physician's ability to administer a high level of care to diagnose and treat illness, offer and implement strategies to continuously improve patient health and wellness, offer advice and resources to prevent disease in patients, and provide not only physical treatment, but also emotional support as the physician cares for patients and interacts with patients' families and support systems.

Practice-Based Learning and Improvement

The ACGME Core Competency of Practice-Based Learning and Improvement shows the ability to comprehend relevant information and a commitment to lifelong learning. Demonstration of competency in PBLI occurs when a resident, and later, a physician, displays the ability to:

- investigate and evaluate patient care practices
- appraise and assimilate scientific evidence, and
- improve the practice of medicine.

Patient Care and Procedural Skills

The ACGME Core Competency of Patient Care and Procedural Skills highlights the necessity of physicians maintaining a patient-centered approach to health care. This entails forming a bond of trust between patient and provider.

A physician will meet all the requirements for this competency when they are able to demonstrate an ability to listen and absorb medical histories, diagnose, properly inform and educate, and prescribe and perform necessary procedures in a way that maximizes patient comfort.

Physicians that embody the competency of Patient Care and Procedural Skills will demonstrate their knowledge with the ability to:

- Gather essential and accurate information about the patient
- Counsel patients and family members
- Make informed diagnostic and therapeutic decisions
- Prescribe and perform essential medical procedures
 - Recognize the indicators for procedures

²⁶ Accredited Council for Graduate Medical Education. Milestones Guidebook for Residents and Fellows. Six Core Competencies. <https://www.acgme.org/globalassets/pdfs/milestones/milestonesguidebookforresidentsfellows.pdf>

- Describe the procedure in appropriate language for patients and caretakers
- Acknowledge the impact of the procedure on patient and family
- Competently perform all medical procedures required for their scope of practice
- Perform the procedure in a way that maximizes patient comfort
- Provide effective health management, maintenance, and prevention guidance

Systems-Based Practice

Systems-Based Practice is often seen as a relatively abstract concept for physicians. Whereas most of the ACGME Core Competencies reflect what happens as a physician is interacting with patients on a day-to-day basis, this core competency focuses on the underpinnings of health care in a good medical practice: safety and quality in health care, physician advocacy, health insurance, health care economics, transitions of care, different health care systems, pay for performance, patient centered medical home, and chronic care. What do all of these diverse facets of medical practice have in common? They all operate by systems. In fact, it is safe to say that if good systems can make a medical practice, then bad systems can certainly break one.

Health care does not exist in a vacuum and all physicians participate in the health care system as a whole: working in the health care field, operating under government regulations, dealing with health insurance, maintaining certification, and more. From the moment a physician makes an appointment with a new patient, he or she is participating in Systems-Based Practice. Therefore, physicians must be aware of the health care systems in which they will operate and have the ability to provide high-quality, cost-effective medical care in the context of these systems and their attendant resources.

Sub-competencies for System Based Practice

- Work effectively in various health care delivery settings and systems relevant to their clinical specialty.
- Coordinate patient care within the health care system relevant to their clinical specialty.
- Incorporate considerations of cost awareness and risk/benefit analysis in patient care.
- Advocate for quality patient care and optimal patient care systems.
- Work in interprofessional teams to enhance patient safety and improve patient care quality.
- Participate in identifying systems errors and in implementing potential systems solutions.

Medical Knowledge

Medicine is constantly evolving, and even a seasoned physician with years of experience hasn't "seen it all." A desire for and an understanding of the need for a lifelong-learning approach to the practice of medicine is a requisite attribute for physicians providing quality health care. For this reason, the ACGME Core Competency of Medical Knowledge seeks to ensure that residents are trained to continually investigate, question, and seek new knowledge. But knowledge without application is fruitless. Sharing those best practices with medical colleagues and employing that knowledge in the diagnosis and treatment of patients is equally as important as obtaining it.

Sub-competencies for Medical Knowledge

The Medical Knowledge sub competencies break down into manageable pieces—the skills and attributes that comprise this core competency. These include being able to demonstrate:

- An investigative and analytical approach to clinical problem solving and knowledge acquisition.
- An ability to apply medical knowledge to clinical situations.
- An ability to teach others.

Interpersonal and Communication Skills

To successfully master the ACGME Core Competency of Interpersonal and Communication Skills, a resident physician needs to demonstrate the ability to effectively exchange information with patients, their families, and professional associates.

Effective communication is a two-way street. It requires the resident to be both an active listener as well as a clear, articulate speaker. The ability to receive information is as important as the ability to transmit it to others. To do this, physicians must develop meaningful relationships with not only their patient but the patient's family and the other medical professionals and health care team members they interact with on a daily basis.

The Interpersonal and Communication Skills core competency can be dissected into two sub competencies. These are:

- Create and sustain a therapeutic relationship with patients and families.
- Work effectively as a member or leader of a health care team.

Professionalism

As the culmination of the ACGME Core Competencies, the Professionalism standard speaks directly to the attitude and behavior of the resident physician. The expectation

for all medical professionals is that each and every one will treat all people with respect, compassion, and dignity. Patient needs will supersede a resident's self-interest. And residents accept and understand that they are accountable to not only the patient but also to their colleagues and society as a whole.

Lastly, the Professionalism competency holds fast to the principle of treating all the diverse patient populations with sensitivity and respect. A professional physician will understand and recognize the unique effects of age, gender, culture, race, religion, disability, and sexual orientation on a patient's health and well-being and act accordingly to provide care that is cognizant of these cultural ramifications.

To better evaluate a physicians' capabilities in the Professionalism Core Competency, the following sub-competencies give a more detailed breakdown of the attitudes and behaviors required. These include:

- Demonstrating Professional Conduct and Accountability
- Demonstrating Humanism and Cultural Proficiency
- Maintaining Emotional, Physical, and Mental Health, and Pursuing Continual Personal and Professional Growth.

Appendix I

DNV Accreditation Standards²⁷

“DNV Interpretive Guidelines” state the following regarding performance, competency, and indicator measurement:

1. The organization shall continually evaluate the performance/competency of staff. This process of evaluation shall include the use of indicators that will objectively measure the ability of staff to perform all job duties as outlined in the job description. These indicators may address one or more of the following:
 - Variations and problem processes identified through the analysis of outcomes measurement as required by the QMS;
 - High-risk, low volume procedures;
 - New technology/equipment/processes;
 - Customer satisfaction feedback;
 - Scheduled training session outcomes;
 - Staff learning needs assessments that include variations identified through prior staff performance measurement;
 - Staff feedback;
 - Medical staff feedback; and,
 - Requirements of federal or state law.
2. The organization will have a policy and procedure for sharing results of individual performance evaluations/competence assessment with staff members that allows for staff feedback within a timeframe defined by the organization, not to exceed one calendar year. The organization may modify indicator measurement for contract staff based on organization outcomes and frequency of service of individuals. This measurement modification will be made when needed and shall be justified by data analysis.

²⁷ DNV. Accreditation Standards. <https://www.dnv.us/assurance/healthcare/ac.html>.

3. The organization shall aggregate the objective performance data from sources that may include individual evaluations, incident reports, risk management, staff and patient feedback, and/or data analysis to identify variations for further training, coaching, and mentoring. In order to continually improve the fulfillment of their job responsibilities, the organization shall require each staff member, including contract staff, to participate in continuing education as required by individual licensure/certification, professional association, law or regulation, or organization policy.²⁸

DNV Surveyor Guidance:

1. In a sampling of personnel records, verify that the organization has a performance/competency evaluation process that includes appropriate measures as stated within the Interpretive Guidelines for SM.7.
2. Verify the policy and practice the organization uses to validate the competency of staff occurs within a specified timeframe no less than once per calendar year.
3. Verify the policy and practice that the organization uses to measure contract staff performance is based upon outcomes and frequency of service.
4. Verify that the organization requires and makes provisions for each staff member, including contract staff, to participate in continuing education as required by individual licensure/certification, professional association, law or regulation, or organization policy.

²⁸ DNV Accreditation Standards. Interpretive Guidelines. <https://www.dnv.us/assurance/healthcare/standards.html?>

Appendix J

The Joint Commission Accreditation Standards²⁹

Focused Professional Practice Evaluation (FPPE)

From The Joint Commission's Critical Access Hospital Manual:

The focused professional practice evaluation is a process whereby the medical staff evaluates the privileged specific competency of the practitioner that lacks documented evidence of competently performing the requested privileges at the organization. This process may also be used when a question arises of a currently privileged practitioner's ability to provide safe, high quality patient care.

A period of FPPE is required for all new privileges. This includes privileges requested by new applicants and all newly requested privileges for existing practitioners. There is no exemption based on board certification, documented experience, or reputation.

FPPE Design

The FPPE process must be pre-defined and consistently implemented for all newly requested privileges. The performance monitoring process must also be clearly defined and include, at a minimum, the following:

- Criteria for conducting performance evaluations,
- Method for establishing the monitoring plan specific to the requested privilege,
- Method to determining the duration of performance monitoring, and
- Circumstances under which monitoring by an external source is required.

The period of FPPE begins at the time privileges are granted, regardless of which process was followed (e.g., temporary, expedited, full privileges, etc.). For example, if temporary privileges are granted on July 1, 2021, however, the governing body does not meet until September 15, 2021, the period of FPPE starts July 1, 2021. The 2-year reappointment cycle also begins July 1, 2021 and ends June 30, 2023. The FPPE requirements also apply when temporary privileges are granted for a limited period of time to meet an important patient care need.

²⁹ The Joint Commission. Accreditation Standards. <https://www.jointcommission.org/standards/>

FPPE Data

Both qualitative and quantitative criteria (data) should be considered when designing the process. For example, limiting criteria to quantitative data may only represent the presence or absence of information but may not reflect the quality of the information reviewed. Consider the following:

Qualitative data or “categorical” data, may be described as data that “approximates and characterizes” and is often non-numerical in nature. This type of data may be collected through methods of observations, discussion with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc.

Examples may include, but are not limited to:

- Description of procedures performed,
- Periodic chart review (quality/accuracy of documentation, appropriateness of tests ordered/procedure performed) patient outcomes
- Types of patient complaints
- Code of conduct breaches
- Peer recommendations
- Discussion with other individuals involved in the care of patients. (i.e., consultant, surgical assistants, nursing, administration.)

Quantitative data often reflects a certain quantity, amount or range and are generally expressed as a unit of measure. Contrasted with qualitative data, quantitative data generally relates to data in the form of numerical quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, timeframes, etc. Example may include, but are not limited to:

- Length of stay trends
- Post-procedure infection rates
- Periodic chart review (Dating/timing/signing entries, Telephone orders/Verbal Orders authenticated within defined time frame, Presence/absence of required information (H&P elements, etc.)
- Number of H&P updates completed within 24 hours after inpatient admission/registration
- Compliance with medical staff rules, regulations, policies, etc.
- Documenting the minimum required elements of and H&P update
- Compliance with core measures

FPPE Data Sources

The data source used for the FPPE process must include practitioner activities performed at the organization where privileges have been requested this may include activities performed at any location that falls under the organization's single CMS certification number (CCN) for example if an organization operates two hospitals that fall under the same CCN number, data from both hospital locations may be used.

In a multihospital system where each hospital operates independently under separate CCN numbers, data from those entities may be used to supplement local data. In multi-hospital systems where each hospital operates independently under separate CCN numbers, data from those entities may be used to supplement local data.

Low-Volume Practitioners

When practitioner activity at the local level is low or limited, supplemental data may be used from another CMS certified organization where the practitioner holds the same privileges. The use of supplemental data may **not** be used in lieu of a process to capture local data.

Organizations choosing to use supplemental data should assess and determine the supplemental data's relevance, timeliness, and accuracy. Examples where supplemental data could be used may include but are not limited to:

- Activity is limited to periodic on-call coverage for other physicians or groups
- Occasional consultations for a clinical specialty

Consistent with The Joint Commissions "Medical Staff" chapter, the medical staff must develop policies and procedures which ensure oversight of local data and the use of supplemental data.

FPPE for Non-Inpatient Areas

Privileges are required for any practitioner providing a medical level of care/decision-making, therefore, FPPE applies to all settings/locations included in the scope of the hospital survey. Examples of settings may include but are not limited to: On and off-campus outpatient services, clinics, hospital owned physician office practices, free standing emergency/urgent care centers etc.

Ongoing Professional Practice Evaluation (OPPE)

OPPE identifies professional practice trends that may impact the quality and safety of care and applies to all practitioners granted privileges via the Medical Staff chapter requirements. A well-designed process supports early detection and response to performance issues that could negatively impact patient outcomes.

Goals of OPPE

The goals for OPPE include:

- A qualitative and quantitative data-driven process to identify performance trends that may require taking steps to improve performance (e.g., implementing an FPPE review).
- Establishing an objective, data-driven foundation for making re-privileging decisions.

Design of OPPE

The OPPE design should have a clearly-defined process that includes elements, such as:

- Responsibilities for data review, as defined by the medical staff that may include:
 - Department chair or the department as a whole
 - Credentialing Committee
 - Medical Executive Committee
 - Special committee of the organized medical staff
 - Frequency of review
 - The process for using data for decision-making
 - The decision process resulting from the review (continue/limit/deny privilege)
 - Frequency of Review
 - The organized medical staff defines the frequency for data collection.
- However, the timeframe for review of the data cannot exceed every 12 months.

OPPE Data

Qualitative and quantitative criteria (data) that has been approved by the medical staff, should be designed into the process. For example, limiting criteria to quantitative data may only represent the presence or absence of information but may not reflect the quality of the information reviewed. Consider the following:

Qualitative Data

Qualitative or 'categorical' data may be described as data that 'approximates and characterizes' and is often non-numerical in nature. This type of data may be collected

through methods of observations, discussion with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc.

Examples may include, but are not limited to:

- Description of procedures performed
- Periodic chart review
- Quality/accuracy of documentation
- Appropriateness of tests ordered/procedures performed
- Patient outcomes
- Types of patient complaints
- Code of conduct breaches
- Peer recommendations
- Discussion with other individuals involved in the care of patient(s), e.g., consultants, surgical assistants, nursing, administration, etc.

When the data being collected is related to the quality of performance, e.g., appropriate management of a patient's presenting condition, or the quality of the performance of a procedure, then the organized medical staff should determine that someone with essentially equal qualifications would review the data.

Quantitative Data

Quantitative data often reflects a certain quantity, amount or range and are generally expressed as a unit of measure. Contrasted with qualitative data, quantitative data generally relates to data in the form of numerical quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, time frames, etc.

Examples may include, but are not limited to:

- Length of stay trends
- Post-procedure infection rates
- Periodic chart review
- Dating/timing/signing entries
- T.O./V.O. authenticated within defined time frame
- Presence/absence of required information (H & P elements, etc.)
- Number of H & P updates completed within 24 hours after inpatient admission/registration
- Compliance with medical staff rules, regulations, policies, etc.
- Documenting the minimum required elements of an H & P update
- Compliance with core measures.

OPPE Data Sources

The data source used for the OPPE process must include practitioner activities performed at the organization where privileges have been requested. This may include activities performed at any location that falls under the organization's single CMS Certification Number (CCN). For example, if an organization operates two hospitals that fall under the same CCN number, data from both hospital locations may be used. In multi-hospital systems where each hospital operates independently under separate CMS CCN, data from those entities may be used to supplement local data.

Low-volume Practitioners

When practitioner activity at the 'local' level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data's relevance, timeliness, and accuracy.

Examples where supplemental data could be used may include, but are not limited to:

- Activity is limited to periodic on-call coverage for other physicians or groups occasional consultations for a clinical specialty.
- Consistent with the "Medical Staff" chapter, the medical staff must develop policies and procedures which ensure oversight of local data and the use of supplemental data.

OPPE for Non-Inpatient Areas

Privileges need to be granted to anyone providing a medical level of care, i.e., making medical diagnoses or medical treatment decisions, in any setting that is included within the scope of the hospital survey. The settings can include inpatient, on-campus outpatient, off campus clinics, hospital owned physician office practices, etc.

OPPE applies to any privileges granted to be exercised in any setting and/or location included within the scope of the hospital survey. The privileges are often the same as those for inpatient care, treatment, and services, therefore, separate privileges based on 'location' would not be required. If the non-inpatient settings do not have the same clinical record system or information technology, collecting data may be more difficult, but if the privileges are the same, the data collected should be the same.

Using the OPPE Data in Decision-Making

The information resulting from the evaluation needs to be used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed. Based on the analysis, several possible actions could occur, for example:

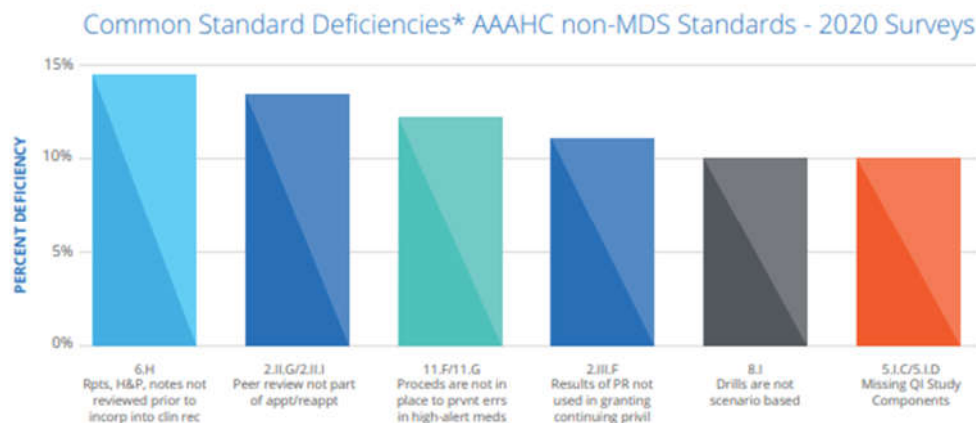
- Determining that the practitioner is performing well or within desired expectations and that no further action is warranted
- Determining that a performance issues exists and requires a focused evaluation – see MS.08.01.01 EP 5.
- Revoking the privilege because it is no longer required
- Suspending the privilege, which suspends the data collection, and notifying the practitioner that if they wish to reactivate it, they must request a reactivation.

OPPE evidence of these determinations would need to be available at the time data is reviewed.

Appendix K

Accreditation Association for Ambulatory Health Care

Accreditation Association for Ambulatory Health Care (AAAHC) focuses exclusively on accreditation services for ambulatory healthcare. AAAHC seeks excellence in quality and peer review processes. As seen below, credentialing, privileging and peer review were the highest common standard deficiency in AAAHC's 2020 Surveys.



AAAHC Recommendations for Compliance

- Privileged health care providers must participate in the development of peer review criteria.
- The peer review process should not be limited to review of clinical records but should also incorporate other items such as infection rates, hospital transfer, adverse event rates, patient satisfaction survey results, and compliance with medical staff rules and regulations as well as clinically based criteria decided by the privileged health care providers.
- The peer review process should be an ongoing review of all providers and should not be limited to incident based review.
- The results of peer review must be part of the credentialing process, communicated to the governing body and incorporated into the QI program.

Appendix L

CMS Regulations

CMS regulations state the following regulation regarding quality monitoring of practitioners.

\$482.22 (a) (1) Tag: A-0340

(1) The medical staff must periodically conduct appraisals of its members.

Appendix M

NPDB Glossary of Terms

Adverse Action

(1) An action taken against a practitioner's clinical privileges or medical staff membership in a health care organization, (2) a licensure disciplinary action, (3) a Medicare/Medicaid Exclusion action, or (4) any other adjudicated action.

Formal Peer Review Process

The conduct of professional review activities through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing.

Health Care Quality Improvement Act of 1986 (NPDB definition)

As amended Title IV of Public Law 99-660; legislation intended to improve the quality of medical care by encouraging hospitals, State Licensing Boards, and other health care organizations, including professional societies, to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent practitioners to move from state to state without disclosure or discovery of the practitioners' previous damaging or incompetent performance.

Medical Malpractice Payment

A monetary exchange as a result of a settlement or judgment of a written complaint or claim demanding payment based on a physician's, dentist's or other licensed health care practitioner's provision of or failure to provide health care services; and may include, but is not limited to, the filing of a cause of action, based on the law of tort, brought in any state or Federal Court or other adjudicative body.

Professional Review Action

An action or recommendation of a health care entity: (1) taken in the course of professional review activity; (2) based on the professional competence or professional conduct of an individual physician, dentist, or other health care practitioner which affects or could affect adversely the health or welfare of a patient or patients; and (3) which adversely affects or may adversely affect the clinical privileges of the physician, dentist, or other health care practitioner.

This term excludes actions which are primarily based on: (1) the physician's, dentist's, or other health care practitioner's association, or lack of association, with a professional society or association; (2) the physician's, dentist's, or other health care practitioner's fees or the physician's, dentist's, or other health care practitioner's advertising or engaging in other competitive acts intended to solicit or retain business; (3) the physician's, dentist's, or other health care practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis; (4) a physician's, dentist's, or other health care practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional; or (5) any other matter that does not relate to the professional competence or professional conduct of a physician, dentist, or other health care practitioner.

Professional Review Activity

An activity of a health care entity with respect to an individual physician, dentist, or other health care practitioner: (1) to determine whether the physician, dentist, or other health care practitioner may have clinical privileges with respect to, or membership in, the entity; (2) to determine the scope or conditions of such privileges or membership; or (3) to change or modify such privileges or membership.