

Community Hospitals and Wellness Centers
CHWC Montpelier Hospital (CAH)
CHWC Bryan Hospital
CHWC Archbold Hospital

MEDICAL STAFF SERVICES POLICY & PROCEDURE

SUBJ: FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

DATE ISSUED: 11/09

REVISED:

REVIEWED: 10/11, 10/13, 10/15, 7/18, 7/21

POLICY NUMBER: **MD0010**

I. POLICY

The organized medical staff is responsible for the evaluation of privilege-specific competence of the medical staff and advanced practice providers. A time-limited period of evaluation (Focused Professional Practice Evaluation) shall be conducted of all practitioners when clinical privileges are initially granted. When a question arises about a practitioner's ability to provide safe, quality patient care, a focused evaluation may be conducted. The medical staff also ensures that the performance of all practitioners holding privileges at Community Hospitals and Wellness Centers is evaluated on an ongoing basis.

II. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

- A. A period of evaluation will be conducted for all practitioners at the time privileges are initially granted. This evaluation is time-limited and intended to confirm the practitioner's competency specific to the privileges granted.
 - 1. General criteria, as well as service-specific criteria for the focused practice evaluation for initially granted privileges are further defined in the Medical Staff Bylaws (Article 2, Section 2.5 - Provisional Period). Additional criteria are defined in department specific documents.
- B. A focused evaluation of a practitioner's performance may be initiated when there is a question as to the practitioner's ability to provide safe, quality patient care.
 - 1. A focused evaluation may be recommended as result of a single event or indication of a clinical practice trend. Other triggers for a focused evaluation include:
 - a. A pattern of unacceptable, unprofessional or unethical behavior
 - b. Actions detrimental to patient safety or to the delivery of quality patient care within the hospital

- c. Persistent failure to follow established hospital and Medical Staff Bylaws, Rules and Regulations, and/or policies
- d. Findings from peer review or other ongoing practice evaluation activities that do not meet applicable professional standards
The evaluation will be conducted using the approved criteria.

A focused review may be initiated by a medical staff committee or by the Medical Executive Committee (MEC). Other medical staff participants in the focused review shall be selected by the MEC.

- 2. To the extent possible, the focused evaluation shall be completed within six (6) months from the date the focused review is initiated, but may be extended by the MEC if the practitioner's activity is insufficient to complete the focused evaluation process. Preliminary findings will be presented to the MEC. The practitioner will be notified, in writing, of the findings and shall be given an opportunity to respond and present information for further consideration. Since the practitioner is given an opportunity to present information which may be considered in his review, the MEC should receive the final report from the Peer Review Committee one month following receipt of the information. The final report will be presented to the MEC who shall make final recommendations regarding corrective actions, if needed, and shall notify the practitioner.
 - a. Corrective actions to resolve performance issues must be clearly defined. A follow-up report on the practitioner's performance, specific to the original issues(s) of concern, will be presented by the appropriate committee chair to the MEC within two (2) months of the date the practitioner was notified of the focused review findings and recommendations.

C. Circumstances that may require an external review:

- 1. Litigation - When dealing with the potential for litigation as determined by Risk Management.
- 2. Ambiguity - When dealing with ambiguous or conflicting recommendations from internal reviewers or medical staff committees, or when there does not appear to be a strong consensus for a particular recommendation.
- 3. Lack of Internal Expertise
 - a. When no one on the medical staff has adequate expertise in the specialty under review; or
 - b. When the only practitioner on the medical staff with the expertise are partners, associates or direct competitors of the practitioner under review, and this potential for conflict of interest cannot be appropriately resolved by the medical staff.
- 4. New Technology - When a medical staff member requests permission to utilize new technology or perform a procedure new to the organization and the medical staff

does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

5. Miscellaneous Issues - When the medical staff needs an expert witness for a fair hearing, for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring.

D. External Peer Review Process

The following process will be initiated for any case that has been identified that may require external peer review:

1. Approval from MEC will be obtained.
2. The Chief of Staff at the external review facility will be contacted; or a call will be placed to a peer review organization for approval/notification.
3. All required documentation will be sent to the external peer reviewer.
4. Outcomes from external peer reviewer will be forwarded to the Peer Review Committee for review and further recommendation(s) reported to MEC.
5. MEC will review and consider the recommendations of the Peer Review Committee, and determine what actions it will recommend; and
6. Submit a summary of the MEC's actions to the Board of Directors.

Approval:

Credential/Bylaws Committee: 07/21

Medical Staff: 08/21

Board of Directors: 08/21