Name of Policy: **Focused Professional Practice Evaluation Policy** **Policy Number**: 3364-87-38 **Approving Officer**: Chief of Staff **Responsible Agent:** Chief Medical Officer **Scope**: All University of Toledo Campuses	THE UNIVERSITY OF TOLEDO MEDICAL CENTER **Effective date**: 09/01/2023 **Initial effective date**: 03/25/08

	New policy proposal		Minor/technical revision of existing policy
	Major revision of existing policy	x	Reaffirmation of existing policy

A. Policy

It is the policy of the University of Toledo Medical Center and its Medical Staff that a period of focused professional practice evaluation will be implemented for all initially requested privileges and to evaluate the performance of practitioners when issues adversely affecting the provision of safe, high quality care are identified.

B. Definitions

Peer: A peer is defined as any qualified practitioner of similar training or experience who can render an unbiased opinion as to the quality or conduct of care for a case.

Proctor: A proctor is a practitioner who is a member of the Medical Staff or Clinical Associate Staff who has the responsibility of evaluating the performance of a peer. The proctor is appointed by the Clinical Service Chief. The proctor will submit a summary report at the end of the agreed upon proctoring period. UTMC 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.

C. Scope of Services

Applies to all members of the Medical Staff and Allied Health Professional of the University of Toledo Medical Center.

D. Responsibility

Data collection that serves as basis for FPPE is done on an ongoing basis and is reported to or by the UT Central Verification Office. The Chief of Staff screens these reports in consultation with the appropriate Clinical Service Chiefs. Focused professional practice evaluation and intensified review are the responsibility of the Clinical Service Chief with oversight by the Peer Review Committee. The Peer Review Committee will monitor ongoing professional performance and act as a liaison between the Clinical Service Chief and the MEC.

E. Methodologies for Collection of Data

The methodologies to be used for collection of data include, but are not limited to, periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel. A multi tiered/level approach can be used, especially for different privileges (e.g., for some direct observation is appropriate but for others charts audits are more appropriate).

F. Confidentiality

Peer review/quality assurance activities are immune to discoverability according to the State of Ohio Statutes. All activities are to be kept confidential. Only authorized persons will have access to the monitoring data or ability to retrieve this information. Authorized persons include Medical Staff leaders, Hospital Administration, Medical Staff Services personnel and Quality Management personnel.

G. Process

1. Focused Review for New Privileges

a. Criteria for Conducting Performance Evaluation

A period of focused review is required for all new privileges, including privileges for new practitioners, and new privileges for existing practitioners.

Privileges for New Practitioners

New practitioners will be assigned to a Proctor by the Clinical Service Chief. The Proctor and Service Chief will design a written plan of evaluation that focuses on the requested privileges. Assessment of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills and systems-based practice will be considered. Evaluation of procedural competence will also be addressed when applicable. The plan of evaluation will be clearly communicated to the ~~Provisional~~ Staff Member and guidelines for completion of the evaluation will be established. Details of the evaluation plan will be provided to the Credentials Committee who will recommend approval to the Chief of Staff and the Medical Executive Committee. When the practitioner has successfully finished the evaluation period, a recommendation will be made by the Clinical Service Chief for discontinuation of the focused review which may be made to the Credentials Committee who will either approve or deny the request. If at the end of the FPPE the Clinical Service Chief determines that the criteria

set forth were not met or if the Credentials Committee deems the FPPE incomplete the matter will be referred to the PRC for further adjudication.

New Privileges for Existing Practitioners

Existing practitioners requesting a new privilege will be assigned a Proctor for that privilege by the Clinical Service Chief. The Proctor and Service Chief will design a written plan of evaluation. The plan of evaluation will be clearly communicated to the practitioner and guidelines for completion of the evaluation will be established. Details of the evaluation plan will be provided to the Credentials Committee. When the practitioner has successfully finished the evaluation period, a recommendation for discontinuation of the focused review may be made to the Credentials Committee which will either approve or deny the request. If at the end of the FPPE the Clinical Service Chief determines that the criteria set forth were not met or if the Credentials Committee deems the FPPE incomplete the matter will be referred to the PRC for further adjudication.

b. Method for Determining the Duration of Performance Monitoring

The duration of performance monitoring will be defined by the Clinical Service Chief and the Proctor, and approved by the Credentials Committee. Consideration of the following should be made when developing an approach appropriate to the practitioner and the privileges requested.

1) high volume privileges vs. low volume privileges
2) high risk privileges vs. low risk privileges
3) practitioners coming directly from an outside residency/training program
4) practitioners coming directly from a UTMC residency/training program
5) practitioners coming with a documented record of performance of the privilege and its associated outcomes
6) practitioners coming with no record of performance of the privilege and its associated outcomes

The following approached might be considered:

1) focused review for a defined number of admissions
2) focused review for a defined number of procedures
3) focused review for a defined period of time (for infrequently performed privileges, numbers might work better than a time period, especially if the privilege isn’t performed in that time period)

4) grouping very similar privileges together and then evaluate a set number of any mix of the privileges (e.g., any ten from the group will be evaluated to determine competence for the whole group, but do not assess only one privilege from the group)

c. Circumstances Under Which Monitoring by an External Source is Required:

On occasion, external peer review may be requested.

2. Other Focused Reviews

a. Criteria for Conducting Performance Evaluations

Performance monitoring is required when issues adversely affecting the provision of safe, high quality patient care are identified. FPPE can be requested by the Chief of Staff, Peer Review Committee or the MEC and will be executed and monitored by the Clinical Service Chief. The Clinical Service Chief will be responsible for insuring successful completion of the FPPE and will report on the outcome of the FPPE to the Chief of Staff, PRC or the MEC. The MEC will accept, modify or change the Clinical Service Chiefs recommendation and articulate its recommendations to the Clinical Affairs Committee of the Board. The following criteria will be used to indicate the need for performance monitoring:

1) small number of admissions or procedures over an extended period of time that raise the concern of continued competence
2) a growing number of longer lengths of stay than other practitioners
3) unplanned returns to surgery
4) frequent or repeat readmissions suggesting possibly poor or inadequate initial management/treatment
5) patterns of unnecessary diagnostic testing/treatments
6) failure to follow approved clinical practice guidelines, which may or may not indicate care problems

Single incidents or evidence of a clinical practice trend may trigger the need for performance monitoring.

b. Method for Establishing the Monitoring Plan

Existing members who have been notified of the need for focused professional practice evaluation will meet with the Clinical Service Chief to establish a plan for evaluation. This meeting will include a review of all appropriate quality assurance monitoring, of

deviations from standards of care and of untoward events that have occurred. Based on the deficiencies identified, a written plan for evaluation will be established. Details of the evaluation plan will be provided to the Peer Review Committee. When the practitioner has successfully finished the evaluation period, a recommendation for discontinuation of the Intensive Review may be made to the Peer Review Committee which will either approve or deny the request.

c. Method for Determining the Duration of Performance Monitoring

The duration of performance monitoring will be defined by the Clinical Service Chief and the Proctor, and approved by the Peer Review Committee. An approach appropriate to each practitioner and the privileges requested should be used (i.e., high volume privileges vs. low volume, high risk privileges vs. low risk). The following approaches might be considered:

1) focused review for a defined number of admissions
2) focused review for a defined number of procedures
3) focused review for a defined period of time (for infrequently performed privileges, numbers might work better than a time period, especially if the privilege isn't performed in that time period)
4) grouping very similar privileges together an then evaluate a set number of any mix of the privileges (e.g., any ten from the group will be evaluated to determine competence for the whole group, but do not assess only one privilege from the group)

d. Circumstances Under Which Monitoring by an External Source is Required:

On occasion, external peer review may be requested. Criteria for making a determination on whether external peer review will be obtained are as follows:

1) A request by the practitioner of concern who does not believe he/she may receive an unbiased review internally.
2) The department cannot provide an unbiased reviewer based on issues of competitive or partnership practices.
3) In the case that a Clinical Service Chief or Department Chair is the subject of review, this case will be forwarded directly to the Peer Review Committee for consideration and assignment of external peer review if there is no unbiased expert internally.

On the basis of the recommended action of the outside expert opinion, the Medical Executive Committee may determine a need to limit/suspend privileges as addressed in the Medical Staff Bylaws. The Medical Staff may also work in cooperation with the reviewing agency to modify physician behavior in anticipation of such limitations.

(G) Communication

The findings of peer review activities are communicated by the Peer Review Committee to the Medical Executive Committee. A regular report is forwarded to the Board of Trustees at least quarterly to monitor peer review decisions and actions for effectiveness.

Approved by: /s/ Puneet Sindhwani, M.D. Chief of Staff 09/26/2023 Date /s/ Michael Ellis, M.D. Chief Medical Officer 09/26/2023 Date *Review/Revision Completed by:* *Medical Executive Committee*	**Policies Superseded by This Policy:** **Review/Revision Date:** **07/23/08** **08/22/12** **06/26/13** **09/1/2016** **09/01/2023** **Next review date:** **9/1/2026**