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To: Voss Pamela
Subject: FW: FPPE--1/2008

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Background:

Standard MS.4.30 requires a process for Focused Professional Practice Evaluation. There are essentially two components:

- Element of Performance 1 which requires "A period of focused professional practice evaluation is implemented for all initially requested privileges." This would mean all privileges for new practitioners and all new privileges for existing practitioners. The EP was published in January 2007 with an effective date of January 1/2008.

- Elements of Performance 2 - 9 which were relocated from the 2006 standard MS.4.90. These elements address what had previously been termed "Peer Review".

For the purpose of discussion these will be addressed in two separate discussion.

EP 1

A period of focused review is required for all new privileges meaning all privileges for new applicants and all new privileges for existing practitioners. There will be no exemption for board certification, documented experience, or reputation. All applicants for new privileges must have a period of focused review.

The organization would need to design the process to be utilized for the EP 1 practitioners in accordance with the criteria outlined in EP 3:

- criteria for conducting performance evaluations
- method for establishing the monitoring plan specific to the requested privilege
- method to determining the duration of performance monitoring
- circumstances under which monitoring by an external source is required

The organization may choose to use the methodologies for collecting information such as those outlined at MS.4.40 for ongoing professional practice evaluation:

-- periodic chart review

-- direct observation

-- monitoring of diagnostic and treatment techniques

-- discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

Since the process must be consistently implemented (EP 4), the organization may wish to put it in writing. There is no requirement that it be in the medical staff bylaws.

There is nothing in EP 3 that would prevent the design of a multi tiered/level approach. The type of review can certainly be different, especially for different privileges, e.g. for some direct observation is appropriate but for other chart audits are more appropriate.

The duration could also be different for different levels of documented training and experience, e.g.

-- practitioners coming directly from an outside residency program
-- practitioners coming directly from the organization's residency program
-- practitioners coming with a documented record of performance of the privilege and its associated outcomes
-- practitioners coming with no record of performance of the privilege and its associated outcomes

With regard to establishing the monitoring plan specific to the requested privilege, it is important to remember that there is no required provisional period. The provision period when it was required related to appointment to the medical staff and not to privileges. Using a 12 month provisional period for focused review might be burdensome when the volume of activity is very large.

It may be more appropriate to consider a different approach for high volume vs low volume privileges or high risk vs. low risk privileges for example performing a focused review for a defined number of admissions such as the first 5, 10, 20, etc, or a defined number of procedures, such as 5, 10, 20, etc, or for a short period of time such as 1 month or 3 months. For an infrequently performed privilege numbers might work better than a time period especially if the privilege isn't performed in that time period.

While the EP would require an evaluation of each new privilege it could be possible to group very similar activities together and then evaluate a set number of any mix of the privileges for example, any ten from the group will be evaluated to determine competence for the whole group, but you cannot just look at one privilege from the group.

A focused review/peer review process which is triggered by practice indicators which only relate to untoward outcomes, could meet EP's 2 - 9 but would not meet EP 1 for a focused practice review for all privileges for new applicants and new privileges for existing practitioners.

The bottom line principles are:

--The process must be defined
--The process must be consistently implemented as defined
--All new privileges (new applicants and new privileges for existing applicants) must be reviewed in accordance with the defined process

EPs 2-9

The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified (EP 2).

In addition, the triggers that indicate the need for performance monitoring are clearly defined (EP 5). Triggers can be single incidents or evidence of a clinical practice trend.

There is a somewhat fine line between criteria and triggers but triggers are the very obvious issues, e.g., infection rates, sentinel events, perhaps complaints, other events that aren't sentinel like sponges left in during surgery, etc.

Criteria might include:

- small number of admissions or procedures over an extended period of time that raise the concern of continued competence

- a growing number of longer lengths of stay than other practitioners

- returns to surgery

- frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment

- patterns of unnecessary diagnostic testing/treatments

- failure to follow approved clinical practice guidelines--may or may not indicate care problems but why the variance

Issues affecting the provision of safe, high quality patient care and indicate the need for performance monitoring may be identified as part of the ongoing practitioner performance evaluation at MS.4.40. It may also be that the negative or outlier data on a practitioner that will be used to identify the trigger that indicate the need for performance monitoring

The four required components for design of the process are outlined in EP 3:

- criteria for conducting performance evaluations

- method for establishing the monitoring plan specific to the requested privilege

- method to determining the duration of performance monitoring

- circumstances under which monitoring by an external source is required

Since the process must be consistently implemented (EP 9), the organization may wish to put it in writing. There is no standard requiring that it be in the medical staff bylaws.

With regard to establishing the monitoring plan specific to the requested privilege, it is important to remember that there is no required provisional period. The provision period, when it was required, related to appointment to the medical staff and not to privileges.

Using a 12 month provisional period might be burdensome when the volume of activity is very large. It may be more appropriate to consider a different approach for high volume vs. low volume privileges or high risk vs. low risk privileges for example performing a focused review for a defined number of admissions such as the first 5, 10, 20, etc, or a defined number of procedures, such as 5, 10, 20, etc, or for a short period of time such as 1 month or 3 months.

For an infrequently performed privilege numbers might work better than a time period especially if the privilege isn't performed in that time period.

The organization may choose to use the methodologies for collecting information outlined at MS.4.40 for ongoing professional practice evaluation:

-- periodic chart review
-- direct observation
-- monitoring of diagnostic and treatment techniques
-- discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

If an organization's current "peer review" process includes The criteria to be used for identified performance issue (EP 2), defined triggers that indicate the need for performance monitoring (EP 5),the four required components outlined in EP 3, and the remaining requirements at EP's 4 and 6 - 9, it would meet the intent for the existing practitioner covered by EP's 2 - 9.

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