OLIVE VIEW-UCLA MEDICAL CENTER
MEDICAL ADMINISTRATION
POLICY & PROCEDURE

NUMBER: 2716
VERSION: 10

SUBJECT/TITLE: **PROFESSIONAL PRACTICE EVALUATION PROCESS OF THE PROFESSIONAL STAFF ASSOCIATION**

POLICY: The medical staff of Olive View-UCLA Medical Center will monitor and evaluate practitioners' professional performance in order to ensure that patients receive quality services. The professional practice evaluation process is a non-biased activity performed by the medical staff to measure, assess and, where necessary, improve performance and competency on an individual/organization-wide basis.

PURPOSE: To ensure that all professional practice evaluation activities are conducted in a consistent manner throughout the organization. To ensure that all activities are properly designed to be objective and evidence-based, and are effectively functioning throughout the organization. To provide or suggest areas for system-wide improvement.

DEPARTMENTS: **MEDICAL DEPARTMENTS**

DEFINITIONS:
Peer – An individual with essentially similar or higher qualifications
External Peer Review – Referral of an issue/case to a reviewer/expert outside the organization for unbiased specialty review and evaluation
Focused Professional Practice Evaluation (FPPE) **–** A process whereby the organization evaluates the performance of the practitioner for all initially requested privileges and/or when issues affecting the provision of safe, high quality patient care are identified. This is not a "focused review" as defined in the PSA Bylaws.
Ongoing Professional Practice Evaluation (OPPE) – A process whereby the organization evaluates the practitioner's professional performance on an ongoing basis in order to facilitate decisions about maintaining, revising or revoking existing privilege(s) prior to or at the time of renewal
Rate Indicator – Identifies performance differences among physicians using aggregated outcomes.
Rule Indicator – Identifies individual instances of non-compliance with an administrative or clinical rule.
Review Indicator – Identifies an egregious case or event, e.g., unexpected death, for further review.

GOALS:
1. Monitor clinical performance of medical staff practitioners.
2. Monitor for significant trends and performance by analyzing aggregate data

and case findings.
3. Identify opportunities for practice and performance improvement of individual practitioners.
4. Improve the quality of care provided by individual practitioners.
5. Assure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely and useful.

PROCEDURE: The medical staff monitors and evaluates the professional performance of its practitioners in at least the following circumstances:

Upon granting of initial privileges.
In conjunction with the regular review of the activity of its members: OPPE.
Upon identification of issues that may affect the delivery of safe and high quality patient care.

I. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

A. The medical staff will engage in ongoing professional practice evaluation to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow practitioners to maintain existing privileges, revise existing privileges, or revoke an existing privilege prior to or at the time of reappointment.

B. Practitioner profile will be generated at least every 6 months.
   1. The indicators will be selected by the individual departments and various committees and approved by the Peer Review Oversight Committee (PROC). Only indicators relevant to practitioner performance will be used for the practitioner profile.
   2. The indicators will be shared with the medical staff.
   3. Rate, rule and review indicators will be utilized.
   4. The practitioner profile will be kept confidential and will only be distributed to the individual practitioner, the appropriate department chair/designee, medical staff leaders - and Peer Review and Credentials Committees as appropriate.
   5. Predetermined targets or thresholds for acceptable performance will be set by the medical staff for each indicator to ensure consistent interpretation by the practitioner and the medical leaders responsible for reviewing it.
   6. The practitioner profile data should be viewed as a starting point for identifying improvement opportunities. Variation should not be considered definitive without further evaluation and discussion with the involved practitioner. Practitioners are encouraged to

express any concerns or questions they have about the data.

C. The following scoring system for individual cases/events will be utilized:

Provider Issues:

P0: no quality issues identified
P1: minor opportunity for improvement in clinical care identified
P2: significant opportunity for improvement in clinical care identified; a plan for improvement is required, although the content of the plan (verbal counseling, written counseling, etc.), is left to the discretion of the responsible Department, Peer Review Oversight Committee (PROC) or Credentials Committee.

System Issues:

S0: no quality issues identified
S1: minor opportunity for system improvement identified.
S2: significant system issue identified; inter-Departmental issue; consider referral to Patient Safety and/or Hospital Administration.

Off Service Issues:

OFF: Event occurred on or as a result of the action or inaction of another service or department.
Refer to other Department(s).

Resident Action (Attending physician not involved):

RES: A supervising (or the responsible) attending physician was not consulted prior to the action of a resident

D. The practitioner profile data will be reviewed at the Department Peer Review Committee.

1. Follow-up by the Department chair/designee with the practitioner will occur if the threshold for indicators is outside of threshold in any of the following patterns:
   a. More than one time period in a row for an individual indicator
   b. A single egregious case or event.
2. The Department chair/designee will discuss the findings with the practitioner to determine whether or not the issues are actually related to practitioner performance.
3. The Department Peer Review Committee will take one of several actions:
   a. No action if not related to practitioner clinical performance
   b. Develop a plan for improvement with follow up
   c. If unable to resolve, refer to the PROC for advice and resolution
4. All practitioner OPPE data will be forwarded to the Peer Review Oversight Committee every six months.

II. PEER REVIEW OVERSIGHT COMMITTEE (PROC)

A. The PROC has representation from all clinical Departments.

B. The PROC meets at regular intervals at least quarterly.

C. The duties of the PROC are the following:
1. Review Departmental peer review reports.
2. Review OPPE variances as submitted by the Departments, specifically addressing issues not resolved at the Departmental level.
3. Review, evaluate and consult on any FPPE's recommended by departments.
4. Initiate a FPPE after review and evaluation of Departmental reports.
5. Submit outcomes and recommendations to the Credentials Committee.
6. Provide a forum to resolve interdepartmental peer review issues and address concerns regarding intradepartmental peer review processes.

III. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A. For initially requested privileges by new practitioner (proctoring), requested privileges for new procedures by existing practitioner, and practitioners returning from Leave of Absence as deemed appropriate by the Department Chair:
1. Requested privileges and performance shall be monitored utilizing the medical staff's approved standardized proctoring forms.
2. The form is completed by the proctor, submitted for review and signature by the Chair, and then forwarded on to Medical Staff Credentials Committee.
3. The Credentials Committee will forward final recommendation to Medical Executive Committee for action.

B. For issues that have been identified through the OPPE and other processes that may affect the delivery of safe and high quality patient care:
1. Medical staff performance concerns that have been identified according to established criteria in areas such as the following:
a. Prescription Errors
b. Blood usage appropriateness
c. Medical record delinquencies

d. Patient complaints
e. Reoperations/Readmissions
f. Malpractice claims

2. Situations that may trigger performance monitoring include, but are not limited to:
   a. Unexpected patient death directly related to the practitioner's performance
   b. "Sentinel Events", as defined by the Joint Commission, directly related to the practitioner's performance
   c. Any single egregious P2 case or event directly related to the practitioner's performance.
   d. One P2 case/event in each of two (2) consecutive six-month OPPE review periods.
   e. A patient care rate indicator outside of threshold in each of two (2) consecutive OPPE review periods.
   f. The practitioner is cited for quality issues from an outside peer review, regulatory, or quality improvement organization requiring a plan for improvement.
3. The involved Department in conjunction with the Peer Review Oversight Committee (PROC) will establish the duration and content for FPPE.
4. The PROC will submit the outcomes and recommendations to the Credentials Committee and notify the practitioner.

C. Performance monitoring may utilize concurrent or retrospective review, including but not limited to:
1. Chart review
2. Tracking performance monitors/indicators
3. External peer review
4. Simulations
5. Morbidity and mortality reviews
6. Discussion with other healthcare individuals involved in the care of patients

D. Performance monitoring may be requested of an external source when it is determined that there are no in-house experts or the in-house experts may have a conflict of interest in performing the performance monitoring.

E. After the FPPE performance monitoring process has been completed, the department or Peer Review Oversight Committee (PROC) must submit a report to the Credentials Committee for review and approval. The Credentials Committee can remove the FPPE placed against the practitioner, recommend further monitoring or take any further action as

indicated in the Professional Staff Association Bylaws.

References:	
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