LAC+USC MEDICAL CENTER
ATTENDING STAFF POLICY GUIDELINES & PROCEDURES

Subject:	Original Issue Date:	Policy #
FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)	4/4/2012	**ASA 115**
	Supersedes: 12/2/2015	Effective Date: 5/4/2022

Departments Consulted:	Reviewed & Approved by:	Approved by:
Medical Administration	Credentials & Privileges Advisory Committee Attending Staff Association Executive Committee	(signature on file) President, Attending Staff Association

I. PURPOSE:

The purpose of this policy is to formalize a Focused Professional Practice Evaluation (FPPE) process at LAC+USC Medical Center. This process shall be under the review and approval of the Credentials and Privileges Advisory Committee, Attending Staff Association (ASA), and the ASA Executive Committee of the LAC+USC Medical Center.

To set forth the policy for conducting focused professional practice evaluation:

A. For the evaluation of privilege-specific competence of all new practitioners and new privileges for existing practitioners.

   Proctoring for initial and new privileges is a component of the FPPE process. The proctoring process will be followed in accordance with the Bylaws of the Attending Staff Association and in individual clinical department policies.

B. When there is concern about a currently privileged practitioner's ability to provide safe, high-quality patient care as identified through the peer review/ongoing professional practice review process, such as the following shall include, but not be limited to:

   1. significant patient injury or death;
   2. critical clinical events reported to Risk Management;
   3. unexpectedly adverse outcomes given severity of illness;
   4. performance of a procedure for an inappropriate reason;
   5. failure to follow Association policy, rules and regulations or bylaws with potential harm to a patient;
   6. significant patient or staff complaint or grievance concerning an individual patient;
   7. disruptive or inappropriate conduct or activities as described in these bylaws;
   8. patient care concerns by a third-party payers or regulatory agencies; and
   9. specific cases meeting the provider's departmental and/or hospital wide quality improvement clinical indicators of ongoing professional practice evaluation (OPPE).

DEFINITIONS

Practitioner: any physician, dentist, podiatrist, allied health professional or clinical psychologist applying for or exercising clinical privileges in the Medical Center.

Clinical Privileges: the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, surgical, dental, or podiatric or clinical psychological services in the Medical Center.

Proctoring: the process of evaluating an individual practitioner's or mid-level provider's current competence of privileges granted.

II. POLICY:

Scope: All members of the medical staff, and allied health professionals granted privileges and who are licensed in the State of California to provide care, treatment, and services without direct supervision (i.e., Advanced Practice Registered Nurses, Physician Assistants), hereafter referred to collectively as practitioners in this policy.

It is the policy of the LAC+USC to conduct appropriate monitoring of the care delivered by its practitioners, and to promote safety and high-quality health care for its patients.

The practice of practitioners will be monitored on an ongoing basis, consistent with the policy regarding peer review & ongoing professional practice evaluation. Ongoing evaluation may identify patterns, outcomes, complications, or other indicators associated with the practice of a specific individual that suggest the need for focused evaluation in accordance with this policy. Additionally, as of January 2008, privileges of all new practitioner and newly approved privileges for existing practitioners will require focused evaluation.

All findings and information associated with any focused professional practice evaluation shall be considered as confidential and protected under the California State Law, including Evidence Code Section 1157 relating to medical professional peer review documents and Government Code Section 6254(c) relating to personnel records. This process will allow the organized medical staff through the Credentials Committee, ASA Executive Committee, and individual departments to monitor and evaluate the practitioner's professional performance. This policy shall ensure compliance with all elements of the Joint Commission's expectations for FPPE.

III. PROCEDURE:

A. **CURRENTLY PRIVILEGED PRACTITIONERS**

1. If at any time, concerns are raised relative to a practitioner's current clinical competence, practice behavior, and/or ability to perform any of his or her privileges, a period of focused evaluation may be indicated. Examples include but are not limited to: (1) information obtained from ongoing evaluation or peer review activities; (2) other evidence suggesting that a practitioner's performance does not fall within the accepted practice guidelines or standards of care; and (3) staff or patient-related complaints. A focused review may be triggered by a specific or single incident, a sentinel or adverse event, evidence of trends in clinical practice, or other

circumstances indicating that patient safety may be compromised.

2. Such matters shall be brought to the appropriate medical staff department chairman. After consideration of the facts available, the Department shall designate an individual (for example the Department Peer Review Chair, or Department Chair/Chief or Vice Chair, or request the ASA Chief of Staff to conduct a focused evaluation as appropriate. Upon review of the findings, the Department may choose to refer the matter to the Credentials & Privileges Advisory Committee.

3. **Criteria** – Type of length of monitoring is based on the triggering issue/specialty-specific data indicators:

    a. Chart review, which may include audits by non-medical staff personnel based on medical staff-defined criteria
    b. Direct observation of the practitioner by the proctor
    c. Simulation performance of the practitioner by the proctor
    d. Discussion with other staff involved in the care of each patient
    e. Defined length of time or number of cases
    f. Individual and/or committee review
    g. Review may be extended depending on findings

    The period of FPPE will be based on either time or procedures. This will allow the appropriate focused evaluations based on the volume of indicators or procedures, for example continuing the period of focused evaluation of low volume procedures.

    FPPE Indicator Selection, Review Type and Duration
    Each Clinical Department shall define the appropriate targets and methods to assess competency for respective specialty areas and FPPE indicators as applicable to those specialties.

    Targets and methods for each indicator shall be recommended by individual departments and approved by the Attending Staff Association (ASA) Executive Committee acting for the organized medical staff so that standards can be set across departments. Targets will be set in such a way as to identify variations in practice that may represent unfavorable trends.

    At a minimum, departmental FPPE indicators shall include, but are not limited to the assessment for proficiency of the following six areas of general competencies:

    a. Patient care
    b. Medical/clinical knowledge
    c. Practice-based learning and improvement
    d. Interpersonal and communication skills
    e. Professionalism
    f. Systems-based practice

    FPPE Indicator Approval, Additions and Deletions
    Indicators may be added or removed based on the evolving standards of care, accuracy of data or changes in data systems. Departmental Chairs shall recommend the composition of any department's FPPE indicators (or change in criteria) including

additions and deletions. The ASA Executive Committee shall provide final approval for the composition of all departmental FPPE indicators.

4. **External peer review** - External peer review may be used to inform Association peer review as delineated under these bylaws. The Credentials and Privileges Advisory Committee or the Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member, may obtain external peer review in the following circumstances:

    a. Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action;

    b. No current Association member can provide the necessary expertise in the clinical procedure or area under review;

    c. To promote impartial peer review; and

    d. Upon the reasonable request of the practitioner.

5. **Duration and frequency** - Duration and frequency will take into consideration the different levels of documented training and experience, such as an initial attending that completed his or her training program at the Medical Center. It also will take into consideration any and all requirements for documentation of previous performance for a specific privilege.

    The period of focused review is time limited. The duration, and type of monitoring required will be dependent upon the nature/severity of the situation under evaluation, the type of privilege(s) in question, and the practitioner's overall activity level. The affected practitioner and his/her department chair/department vice-chair/section chair are informed of the duration of the review as well as the mechanisms that will be employed during the review.

6. The initial review period may be extended at the discretion of the Department appropriate designee based upon the extent to which sufficient information to evaluate the practitioner's performance has been obtained. Similarly, the initial method of evaluation may be expanded or supplemented with other methods as needed during the initial and any subsequent review periods.

7. Upon completion of the focused evaluation, significant findings shall be reported to the Department responsible for the Focused Professional Practice Evaluation form (Attachment A). The Department shall evaluate the results of the evaluation and make a recommendation. Recommendations may include, but are not limited to, the following:

    a. No further action required, continue current privilege(s)
    b. Modify or limit privilege(s)
    c. Further need for FPPE

8. The recommendation of the Department, Credentials Committee, or Attending Staff Association Executive Committee, as applicable, is consistent with all other recommendations concerning medical staff status and privilege changes. The Licensed Independent Practitioner (LIP) is also notified of the outcome of the

evaluation and the requirements, if any, relative to future exercise of the privilege(s) in question.

9. Subsequent review following the completion of proctoring or any training required by the Department shall occur to re-evaluate the practitioner's ability to exercise the privileges in question on an independent basis for attendings or indirect basis for allied health professionals.
10. Any practitioner subject to proctoring, additional training, summary suspension or other limitations on his or her privileges shall be entitled to the fair hearing and appeals process subject to the terms defined in the Attending Staff bylaws.

B. **NEW AND EXISTING PRACTITIONERS AND NEWLY REQUESTED PRIVILEGES**

1. A period of focused evaluation is required for all new practitioners or existing practitioner with newly requested privileges and is accomplished through review of hospital-based outpatient procedures privileges and all inpatient admissions. Outpatient and inpatient episodes of care are reviewed by screening all coded, medical record descriptors for specific complication codes and/or procedure codes listed in standard coding texts. The practitioner-specific episodes of care is compared to peer practitioners from the same specialty or subspecialty, where feasible. Focused evaluation for individuals who practice in hospital-based specialties whose performance cannot be measured through the mechanism described above will entail monitoring through appropriate medical staff committees.
2. The duration of focused review shall be for a minimum of six (6) months or until at least five episodes of care are available for review (e.g. office-based specialties), unless otherwise specified by the department for that specialty. If there are no outliers identified upon the completion of the focused evaluation described in 1, the evaluation shall be deemed complete.
3. If statistical outliers are identified through the evaluation described in 1, focused evaluation shall continue and expand to encompass, but not be limited to, one or more of the following:
    a. Retrospective or prospective chart review
    b. Prospective monitoring of clinical practice patterns
    c. Proctoring
    d. External peer review
    e. Simulation
    f. Discussion with other individuals involved in the care of the practitioner's patients
4. Focused evaluation as outlined in 3 above, will be conducted by a medical staff leader (department chair, department vice-chair, section chair) or designee of the Department.
5. If at any time during the focused evaluation a question arises as to the practitioner's competence to exercise the affected privileges and there is concern about imminent threat to patient safety, the bylaws section on summary suspension shall be

followed.

6. At the end of the period of focused evaluation described in 2 above, in the event that the practitioner's activity at LAC+USC Medical Center has not been sufficient to appropriately evaluate his/her competence either:
    a. the LIP shall voluntarily resign the relevant privilege(s), or
    b. the LIP shall submit a written request for an extension of the period of focused evaluation, or
    c. if the LIP has significant volume of the privileges in question at another local hospital, external references (Department or designee at the local hospital) specific to the procedures will be provided and obtained.
7. The period of focused review for individuals who are approved in advance for a leave of absence shall be automatically extended for the duration of the leave of absence.

IV. FPPE Maintenance of Confidentiality

All Practitioner peer review documentation including FPPE shall be maintained as part of each ASA practitioner member's peer review file within the department, Attending Staff Office and/or the Attending Staff Peer Review System and will be kept confidential consistent with ASA confidentiality policy and bylaws standards and any legal privilege of information established by applicable law. Practitioner-specific FPPE report will only be shared with the individual practitioner, the chair/chief of the department and, when indicated, ASA leadership and the Credentials Committee and the ASA Executive Committee for the purpose of evaluating performance trends and to determine whether to continue, limit or revoke an existing privilege(s).

V. FPPE Plan, Review and Actions

A. Attending Staff Association Office Responsibilities

1. Send a letter to the practitioner being proctored containing the following information:
    a. The approved privileges and a description of the proctoring process.
    b. Referral to the location of the FPPE policy and proctoring on the ASO website: www.lacusc.org.
    c. Proctoring forms to be completed by each proctor.
2. Send notification to each hospital department when a practitioner requires proctoring.
3. Periodically submit a FPPE summary report to the Credentials and Privileges Advisory Committee.

B. Department Chair Responsibilities

Each FPPE requires a review and determination by the department chair. Resulting action can be, but is not limited to:

a. documenting in the member's peer review file that the member is performing well or within desired expectations;
b. identifying issues that require a focused evaluation;
c. recommending to the Executive Committee needed changes in hospital systems to

improve patient safety or the quality of patient care.; or

d. recommending corrective action under these bylaws.

Any plan that reflects an unfavorable trend requires follow up by the department chair or designee. Acceptable follow up of an unfavorable trend shall include analysis and, when indicated, corrective actions. Not all unfavorable trends warrant corrective actions but all unfavorable trends must trigger analysis and subsequent review with the provider. If the analysis reveals a concerning practice pattern then it is incumbent on the chair of the department to intervene.

Specific documentation of the corrective actions and supporting data shall be maintained in the individual peer review files and not as part of the practitioner's credentials file.
The credentials file shall include documentation that the FPPE Plan was acceptable or that an unfavorable trend was identified and was reviewed with the provider (signature on profile will suffice), that an analysis was undertaken and that corrective actions were implemented where indicated.

Corrective action/performance improvement plan for an individual practitioner may include, but not limited to the following:

a. Necessary education
b. Counseling
c. Proctoring/mandatory assisting for defined privilege
d. Referral to the Well-Being Committee
e. Suspension of specific privileges
f. Revocation of specific privileges

C. Credentials and Privileges Advisory Committee

1. Maintains the responsibility of monitoring compliance with this policy.

2. Receives and acts upon regular status reports related to the progress of all practitioners required to complete FPPE as well as any issues related to the implementation of this policy.

3. Makes recommendation to the Executive Committee regarding clinical privileges based on information obtained from the FPPE policy and department recommendations, including corrective actions, if any ensuring adherence to the bylaws.

Method of improving performance for a specific privilege shall be consistently applied to any practitioner undergoing FPPE for that privilege.

Decisions to continue, limit or revoke an existing privilege(s) shall be documented and maintained in the credentials file.

The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege. Other existing privileges in good standing should not be affected by this decision.

The FPPE profiles outcomes shall be included in the credentials committee review for consideration of each practitioner's application for renewal of privileges.

D. Attending Staff Association Executive Committee

1. Receives and acts upon reports regarding clinical privileges based on information obtained from the FPPE policy and department recommendations, Credentials and Privileges Advisory Committee including corrective actions, if any, while ensuring adherence to the bylaws.

2. Makes recommendations to the Governing Body/Director regarding corrective actions, while adhering to the bylaws.

In the event of corrective actions or unfavorable decision regarding ongoing privileges, ASA fair hearing and appeal process provided for in ASA Bylaws, Rules and Regulations, shall apply.

VI. Organizational Support

The FPPE process will also be supported by the Department of Quality Improvement, and other medical and hospital staff committees in addition to the individual Medical Departments, the Credentials and Privileges Advisory Committee and the ASA Executive Committee.

RESPONSIBILITY

Attending Staff Association Executive Committee
Credentials and Privileges Advisory Committee
President/Chief of Staff
Clinical Department Chairs
Department of Quality Improvement
Attending Staff
Attending Staff Office

REFERENCES

The Joint Commission Standards, MS.08.01.01
ASA Policy 104
Attending Staff Manual, Bylaws, Rules and Regulations and Department Rules and Regulations
California Evidence Code 1157
California Government Code Section 6254(c)

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