FOCUSED & ONGOING
PROFESSIONAL PERFORMANCE EVALUATION
Practitioner-Specific, Privilege-Specific Medical Staff Decisions Based on Valid, Accurate Clinical Knowledge

The Joint Commission on the Accreditation of Healthcare Organizations (TJC) now requires by published Medical Staff Standards two (2) distinct types of ***performance evaluation to assure current clinical competence*** of physicians and all other practitioners that are credentialed and privileged through the organized medical staff. The Medical Staff Standards require that these clinical performance decisions occur both at initial appointment and consistently throughout membership, including again at reappointment.

FPPE – focused professional performance evaluation (new as of 12/15/2008)
Three (3) types of Focused PPE:

1. New applicants for medical staff membership
2. Existing practitioners requesting new privileges for which the hospital has no documented evidence of their competence; and
3. Practitioners whose current abilities are questioned because:
    a. There are negative performance issues, or
    b. An adequate volume of cases are not available to assess current competence.

Historical Summary:
In 2004, TJC renamed peer review "*Focused Review of Practitioner Performance*" which was later renamed to *Focused Professional Practice Evaluation* (FPPE) and essentially made peer review one of several tools to accomplish FPPE. In 2007, TJC defined two types of reviews aimed at assuring physician competence: the FPPE and "ongoing professional practice evaluation" (OPPE.) The FPPE applies to new applicants for medical staff membership and to existing practitioners requesting new privileges for which the hospital has no documented evidence of their competence. FPPE may also apply to a practitioner whose current abilities are questioned because of negative performance issues or because an adequate volume of cases are not available to assess current competence. In the case of initial medical staff appointments, the hospital must check with primary sources to determine whether the practitioner requesting medical staff membership and privileges has the requisite current training, knowledge, skills and abilities. These same parameters must be evaluated for practitioners during the re-credentialing process, with the additional requirement that granting of privileges is based in part on the results of peer review and OPPE. Proctoring is a form of focused evaluation involving one-on-one evaluation of a practitioner's performance by another peer practitioner (a proctor). Direct observation is used to gauge the ability of the proctoree to perform a procedure or use a new technology. Focused proctoree evaluation may occur retrospectively through peer review if on-site, real-time evaluations are not feasible. In the case where same specialty peer reviewers are not available internally, external peer review can be used as a viable substitute for on-site proctoring.

The FPPE Process: "A period of focused professional practice evaluation is implemented for all initially requested privileges." This means all privileges for new practitioners and all new privileges for existing practitioners. [EP1 – effective 01/10/08] There is no exemption for board certification, documented experience, or reputation. All applicants for new privileges must have a period of focused review. [TJC FAQ's 10/13/08]

FPPE New Privileges Process: the essential principles for the FPPE new privileges process are:

- The process must be defined;
- The process must be consistently implemented; and
- All new privileges (new applicants and new privileges for existing applicants) must be reviewed in accordance with the defined process. [TJC FAQ's 10/13/08]

The process must be pre-defined, and focused professional practice evaluation must be consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. [EP4] There is no requirement that the FPPE process be in the medical staff by-laws or even that it be in writing. However, to be consistently implemented, the organization may decide to put the process in writing. [TJC FAQ's 10/13/08]

Monitoring Plan Duration – there is no requirement for a provisional period (provisional period is related to appointment to membership and is not related 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 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. [TJC FAQ's 10/13/08]

Grouping Privileges for Monitoring – there are various approaches to credentialing practitioners, ranging from specific privilege "laundry lists" to core competency privileging. While TJC requires evaluation of each new privilege, it is possible to group very similar activities together and then evaluate a set number of any mix of the privileges; for example, any 10 from the group will be evaluated to determine competence for the whole group (however, you cannot look at just one privilege from the group). [TJC FAQ's 10/13/08]

Different Levels of Training & Experience for Monitoring – the duration can also be different for different levels of training and experience, such as:

- Practitioners coming directly from 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; and
- Practitioners coming with no record of performance of the privilege and its associated outcomes.

[TJC FAQ's 10/13/08]

OPPE – ongoing professional performance evaluation (new as of 05/27/2009)
Recognizes that there is a need to evaluate practitioners on an ongoing basis rather than at the usual two year reappointment process and allow practitioners to take steps to improve performance on a more timely basis. OPPE applies to practitioners who:

1. Have already been granted patient care privileges;
2. To revise existing privileges; or
3. To revoke an existing privilege prior to or at the time for renewal.

Historical Summary:
In 2007, TJC established OPPE because of the recognition that there is need to evaluate practitioners on an ongoing basis rather than at the usual two year reappointment process and allow practitioners to take steps to improve performance on a more timely basis. OPPE applies to practitioners who have already been granted patient care privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. The revised OPPE process requires a clearly defined process for the evaluation of each practitioner's professional practice which would include the following: who will be responsible for reviewing performance data, how often the data will be received, the process to be implemented to make a decision on whether to continue, limit or revoke privileges, and how the data will be incorporated into the credentials' files. OPPE standards require an evaluation for all practitioners and not just those with performance issues.

FPPE-OPPE Sources of Information

The ***sources of information*** regarding practitioners can be the same sources for both FPPE and OPPE and include:

1. Chart review;
2. Direct observation techniques;
3. Monitoring clinical practice patterns;
4. Simulation;
5. External peer review; and
6. Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.

Proctoring is a form of focused evaluation involving one-on-one evaluation of a practitioner's performance by another peer practitioner (a "proctor"). Direct observation is used to gauge the ability of the proctoree to perform a procedure or to use a new technology. Focused proctoree evaluation may occur retrospectively through peer review if on-site, real-time evaluations are not feasible. In the case where same-specialty reviewers are not available internally, external peer review can be used as a viable substitute for on-site proctoring.

ACGME Current Clinical Competence Framework

Current clinical competence is to be measured in the framework of the six (6) ACGME (Accreditation Council for Graduate Medical Education) Competencies. While some sources have attempted to define these competencies differently than the ACGME and diminish their intent, the following program requirements, directly from the ACGME, are extraordinarily relevant.

1. **Patient Care**
   Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2. **Medical/Clinical Knowledge**
   Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

3. **Practice-Based Learning & Improvement**
   Demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning and to demonstrate skills and habits to be able to meet the following goals:
   - Identify strengths, deficiencies, and limits in one's knowledge and expertise;
   - Continuously set learning and improvement goals;
   - Identify and perform appropriate learning activities;
   - Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
   - Incorporate formative evaluation feedback into daily practice;
   - Locate, appraise, and assimilate evidence from scientific studies related to their patient's health problems;
   - Use information technology to optimize learning; and
   - Participate in the education of patients, families, and other health professionals.

Medical **judgment** is inherent in all three (3) of these competencies, so that judgment is manifested in providing compassionate, appropriate, and effective treatment of health problems balanced with patient-centric health and wellness *and* applying clinical knowledge scientifically to patient care. Judgment is crucial in recognizing professional limits of knowledge and expertise

and in applying learned current state-of-the-art evidence-based science and information to patient care and continuous quality improvement techniques to professional practice.

4. Interpersonal Skills and Communication
   Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals, including:
   - Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
   - Communicate effectively with physicians, other health professionals, and health related agencies;
   - Work effectively as a member or leader of a health care team or other professional group;
   - Act in a consultative role to other physicians and health professionals; and
   - Maintain comprehensive, timely, and legible medical records, if applicable.

5. Professionalism
   Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles, including:
   - Compassion, integrity, and respect for others;
   - Responsiveness to patient needs that supersedes self-interest;
   - Respect for patient privacy and autonomy;
   - Accountability to patients, society, and the profession; and
   - Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

6. Systems-Based Practice
   Demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care, including:
   - Work effectively in various health care delivery settings and systems relevant to their clinical specialty;
   - Coordinate patient care within the health care system relevant to their clinical specialty;
   - Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
   - Advocate for quality patient care and optimal patient care systems;
   - Work in inter-professional teams to enhance patient safety and improve patient care quality; and
   - Participate in identifying system errors and implementing potential systems solutions.

These six (6) areas of competencies require development of ***metrics*** (MS.08.01.03 EP 1-3) to evaluate professional performance, such as:

- Review of operative and other clinical procedure(s) [includes other invasive and non-invasive procedures that place the patient at risk; the focus is on procedures and is not meant to include medications that place the patient at risk];
- Pattern of blood and pharmaceutical usage;
- Requests for tests and procedures;
- Length of stay patterns;
- Morbidity and mortality data;
- Practitioner's use of consultants; and
- Other relevant criteria as determined by the organized medical staff.

ONGOING PROFESSIONAL PERFORMANCE EVALUATION

The revised OPPE process requires a ***clearly defined process*** for the evaluation of each practitioner's professional practice which includes the following:

1. Who will be responsible for reviewing performance data;
2. How often the data will be received;
3. The process to be implemented to make a decision on whether to continue, limit or revoke privileges; and
4. How the data will be incorporated into the credentials files.

OPPE inherently anticipates coordination of efforts between the Quality/Risk processes and staff, the Medical Staff Office, and the organized medical staff. In most healthcare organizations, the Medical Staff Office will undertake recording clinical information generated by the quality/risk staff and integrating that data into the credentialing/re-credentialing process, while individuals and entities of the organized medical staff will perform the peer evaluation of that information.

Monitoring the clinical performance of contracted services is one of the major deficiencies of healthcare organizations. The governing body is responsible for monitoring contracted services [see MS.13.01.01 EP 1; LD.04.03.09 EP 4; and LD.04.03.09. EP 9]. Since credentials and privileges are determined in some instances at the "originating site," this can impose a difficult burden on the governing body and those that provide staff support to that body.

The Standards contemplate when the OPPE process converts to the FPPE process. Elements of Performance 2 requires that organized medical staffs develop ***performance criteria*** to evaluate the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified. Examples of such performance criteria might include but not be limited to:

- Small number of admissions or procedures over an extended period of time that raise the concern of continued competence;
- 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; and
- Failure to follow approved clinical practice guidelines (may or may not indicate care problems, but why the variance should be evaluated).

Performance criteria would logically include indicators from other TJC standards, such as:

- Never Events
- Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery (UP.01.01.01, UP 01.02.01, and UP 01.03.01 and related EPs);

OPPE should also convert to FPPE based on ***triggers*** (see Elements of Performance 5) that indicate the need for performance monitoring and can be clearly defined single incidents or evidence of a clinical practice trend. The performance criteria offer opportunities to read and learn from patient records and hospital documents and data to refine performance criteria into these triggers.

Zero data is, in fact, data. It may be evidence of good performance, e.g. no returns to surgery, no complications, no complaints, no infections, etc. However, it is also important to recognize when a practitioner is not performing certain privileges over a given period of time. TJC states that it would not be acceptable to find at the 2-year reappointment that a privilege has not been performed for this timeframe. Zero performance of a privilege should be evaluated to determine possible reasons, such as the practitioner is no longer performing the privilege (now doing

laproscopically, for example), taking patients needing the procedure to another facility, or a typically rare or infrequent privilege).