NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

MEDICAL STAFF

PRACTITIONER EFFECTIVENESS MANUAL

Revised October 2012

MEDICAL STAFF OFFICE
Ross Hall 1st Floor
700 Children's Drive
Columbus, Ohio 43205
(614) 722-3040

NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

ARTICLE 4: PRACTITIONER EFFECTIVENESS MANUAL **PAGE #**

4.1. Professional Practice Evaluation 3

4.2. Practitioner Health 11
4.2.1. Impaired Practitioners 11
4.2.2. Informal Process 11

4.3. Guidelines for Practitioner In-House Service 14

ARTICLE 4: PRACTITIONER EFFECTIVENESS MANUAL

4.1. Professional Practice Evaluation

A. Purpose

The Hospital's Board of Directors ("Board"), by delegation to its Medical Staff, collects and/or analyzes and reviews credentials and performance data for the evaluation of each Practitioner's current clinical competency in order to determine the Practitioner's eligibility for requested clinical privileges and assure high quality, safe patient care in the Hospital.

B. Professional Practice Evaluation

The Hospital performance improvement program initiatives are designed to: (1) continuously improve the quality of care to patients; and (2) provide for professional practice evaluation that consistently determines the current competency of privileged Practitioners and privileged Specified Professional Personnel ("SPP") (collectively referred to as "Practitioners"). Such activities are peer review protected activities.

A Practitioner's performance evaluation shall be conducted in a uniform and consistent manner by the Practitioner's peers (or selected consultants to the Medical Staff) during:

- The appointment/reappointment and privileging processes.
- On an ongoing basis.
- On a focused basis whenever a quality of care concern arises. In such reviews, all concerns as well as results of tracking and trending of peer review activity shall be considered.

Practitioner competency is evaluated via Professional Practice Evaluation ("PPE") initiatives. Results of these activities will be aggregated, trended and maintained as needed in each Practitioner's Individual Credentials file.

Initiation and monitoring of PPE will be coordinated by an applicable Section/Department Chief with coordination assistance by the Quality Improvement Services and/or the Medical Staff Office.

The results of a PPE may be used to implement change or to improve performance of a Practitioner, a medical specialty, or care practices while fully safe-guarding the confidentiality of the protected peer review process. Should a PPE result in a determination that patient safety is in jeopardy, the provisions of the Medical Staff Bylaws are to be initiated, as applicable.

C. Ongoing Professional Practice Evaluation Process ("OPPE")

Continuous and/or ongoing Professional Performance Evaluation by the Medical Staff of the medical care provided by privileged Practitioners is conducted to ensure the consistent and continuous delivery of high quality safe patient care. OPPE applies to Medical Staff that are Active with Admitting/Management Privileges. The Department Chief, in consultation with the applicable Section Chief is responsible for establishing specific OPPE criteria that will be regularly monitored. Such criteria may include the following categories: activity data (inpatient admissions, consults, procedures, length of stay) and performance data including clinical care, medical / clinical knowledge, practice-based learning and improvement, communication skills, and professionalism. Examples of OPPE forms for Medical and Surgical sections/departments are attached to this policy.

Information used in OPPE may be acquired through multiple resources including the following:

1. Record review.
2. Direct observation.
3. Patient and/or family feedback
4. Monitoring of diagnostic and treatment techniques.
5. Discussion with other individuals involved in the care of each patient including consulting Practitioners, assistants at surgery, nursing, and administrative personnel. The Departments shall, from time to time, review, revise, and create criteria directing the type of data to be collected.

All Hospital OPPE activities are conducted continuously and codified periodically (usually quarterly or semi-annually) to determine if generally accepted standards of care have been met and to determine if opportunities to improve care and care processes exist within the Hospital. Relevent information gleaned from an OPPE will be integrated into performance improvement activities as applicable. OPPE derived data may be used to assign a period of FPPE monitoring to assess the practitioner's current competence, practice behavior, and/or the ability to perform a requested privilege(s).

Hospital OPPE activity is under the direction and guidance of the relevant Section/Department Chief in conjunction with the hospital QIS Department. Data pertaining to the practitioner and department specific metrics will be gathered by the Hospital QIS Department and decision support where possible, codified, and reported to the Section/Department Chief. It is the responsibility of the Chief to periodically review this ongoing practitioner specific data and make recommendations, if necessary to the Credentials Committee of the Medical Staff about the need for a FPPE.

D. Focused Professional Practice Evaluation ("FPPE")

A FPPE is targeted, focused monitoring of competency associated with the exercise of clinical privileges. Professional practice evaluation of Practitioners using the FPPE process should be initiated for:

1. New privileges: all initial (new) privileges (whether a new Practitioner to the Hospital or with an established Practitioner at the Hospital who is granted a new privilege); or

2. Quality of Care Concern: when a specific question or concern arises regarding a currently privileged Practitioner's current clinical competence, and/or professional behavior, and/or the ability to safely perform any privilege.

New Privileges:

Clinical competency monitoring with a FPPE will be conducted for a specified minimum period of time and/or performance volume, consistent with the privilege set as determined by the applicable Section/Department Chief and approved by the Credentials Committee. The FPPE parameters should be formatted as in the example below.

The duration of the FPPE for Dr. _____ shall be for a minimum of (example - three (3) months) or until at least (example - five (5)) episodes of (kind of care activity) are available for evaluation and verification by (the applicable Section / Department Chief or designee).

The Medical Staff Credentials Committee will oversee this privileging process as per Medical Staff Bylaws. The Section/Department Chief or designee(s), in conjunction with the Hospital QIS Department and decision support if applicable, will oversee the performance data gathering, and provide a summary report to the Credentials Committee. Should the Credentials Committee determine that the FPPE results are inconclusive to allow for a privilege-specific competency determination, the FPPE monitoring can be extended for up to one (1) additional year, but not to exceed a total of two (2) years, per FPPE review episode.

Quality of Care Concern:

Quality of care concerns that can initiate a FPPE may include a single untoward clinical incident, a sentinel event, an adverse event, evidence of undesired clinical practice trends, or significant unprofessional behaviors. Specific triggers that automatically generate a FPPE will include:

1. Two serious safety event (SSE) episodes involving the same responsible attending (usually the person on call during the event) within one year
2. One episode of significant disruptive behavior as defined in the NCH Medical Staff code of conduct policy
3. Any adverse drug event prescribing error (ADE) with severity level greater than or equal to 7 involving the responsible attending (usually the person on call during the event)
4. One wrong site surgery involving the responsible attending for the surgical case.

Medical Staff leadership will communicate with the Practitioner and appropriate Hospital leadership, including the Chief Medical Officer during or upon conclusion of FPPE activity that was initiated to assess a quality of care concern and as determined by the Medical Staff Bylaws.

Professional Performance Evaluation, such as FPPE can be accomplished through review of Hospital-based outpatient and/or inpatient procedures or care management using internal or external peer review group(s). Selected outpatient and/or inpatient episodes of care will be reviewed by screening selected medical records for criteria related to care management concerns. Examples of screening criteria may include:

1. Review of operative and other clinical procedure(s) performed and their outcomes (may use internal or external peer review).
2. Pattern of blood and pharmaceutical usage.
3. Requests for tests and procedures.
4. Morbidity and mortality data, including the use of autopsy.
5. Practitioner's use of consultants.
6. Other relevant data as determined by the Medical Staff.

Methods to collect Professional Practice Evaluation data may include:

1. Periodic chart review.
2. Direct observation.
3. Patient and/or family feedback
4. Monitoring of diagnostic and treatment techniques or practices.
5. Discussion with other individuals involved in the care of each patient including consulting Practitioners, assistants at surgery, nursing personnel, and administrative personnel.

Focused evaluation action or work plan(s) may include, but are not limited to, one or more of the following items. The charge to the group conducting the FPPE will suggest which methods to include.

1. Comparison of the Practitioner's inpatient and outpatient complications/outcomes related to his/her peers, regional, national or federal performance standards and/or guidelines, where available.
2. Retrospective, concurrent or prospective medical record review.
3. Proctoring results.
4. External peer review.
5. Simulation results.
6. Discussion with other individuals involved in the care of the practitioner's patients and/or patient cases relative to the substance of the FPPE.

External peer review will be conducted when appropriate internal peer expertise is not available. This circumstance is more likely in the setting of review of a Section/Department Chief.

A FPPE convened due to quality of care concerns may follow the adjudication procedure prescribed in the Medical Staff Bylaws (led by the Vice President of the Medical Staff) or may be conducted by a "peer professional group", consisting of members determined by the relevant Section/Department Chief, Chief Medical Officer, Credentials Committee Chair, and Medical Staff President. This focused "peer professional group" will be appointed jointly by the President of the Medical Staff and the Chief Medical Officer.

E. Results of Professional Performance Evaluation

The information resulting from PPE activity (FPPE and/or OPPE) will be used to determine whether to continue (renew, limit, or revoke) any existing privilege(s) at the time the information is analyzed. Based on the analysis, several actions may occur including but not limited to:

1. Determination that the Practitioner is performing well (or within the desired expectations) and that no action is warranted.
2. Determination that an issue(s) exists that requires a period of FPPE.
3. Determination that an issue(s) exists that requires remediation and/or corrective action.
4. Determination that the privilege(s) should be terminated because current competency has not been established/met/continued.
5. Determination that the privilege should be automatically suspended based upon a failure to exercise the privilege(s) within a designated period of time and notifying the Practitioner that to have the suspension lifted, the Practitioner must submit a written request indicating the intent to exercise the privilege(s) (and providing such additional data as the hospital may require for purposes of determining current competency).
6. Determination that zero performance should trigger a FPPE whenever the Practitioner actually performs the privilege.

In addition, the information will be reviewed on an aggregate basis to determine whether certain privileges should continue to be recognized by the Board of Directors because the privileges are important to the Hospital's mission of providing patient care or whether such privileges should be eliminated.

F. Assessment of Professional Practice Evaluation Process

Not less than annually, a meeting shall be held consisting of the Medical Executive Committee, Section/Department Chief, and members of Hospital administration, including but not necessarily limited to the Chief Medical Officer to assess: 1) the effectiveness of the FPPE, OPPE process; 2) decisions/actions (formal and informal) taken during the prior year; and 3) to determine what changes, if any, should be made to the peer review process as set forth in this Policy. Such meeting(s) may be a part of the agenda of any regularly scheduled meeting or may be called as a special meeting.

Medical Ongoing Professional Practice Evaluation

Provider:	**Department:**
Review Period:	**Section:**

Activity Data (each line item if applicable)	
Total Inpatient Admissions	
Total Inpatient Discharges	
Total Outpatient/Clinic Visits	
Total Consultations	
Total Patient Days	
Average LOS (all patients by this provider)	

Performance Data		**Current Physician Performance (Data)**	**Peer Specialty Range (if available)**	**Expected Performance (range)**	**Previous Performance**
Patient Care					
For LOS - top 2 diagnoses for Specialty					
Diagnosis average LOS in days					
Diagnosis average LOS in days					
Number of Prescribing Error Adverse Drug events (category 6 - 9) wherein practitioner was responsible attending (usually on-call physician) per reporting period					
Number of SSE cases wherein practitioner was attending of record (per reporting period)					
Specialty Specific Indicator per Section/Dept. Chief					
Specialty Specific Indicator per Section/Dept Chief					
Interpersonal & Communication Skills					
Number of Patient/Family Complaints					
Number of Reported Patient/Family Compliments					
Professionalism					
Number of Peer Complaints					
Number of Peer Compliments					
Systems-based Practice					
Number of months on delinquent medical record list					
Number of months on unsigned verbal order list					
Medical/Clinical Knowledge					
Meets Board Certification Requirement		Yes / No			

Document reviewed by Individual Practitioner Comments:	Signature: Date:
Document reviewed/approved by Section/Department Chief Comments:	Signature: Date:

	Expected target met (green)
	Needs Follow-up and continued monitoring (yellow)
	Below Expected Performance (red)

Surgical Ongoing Professional Practice Evaluation

Provider:	**Department:**
Review Period:	**Section:**

Activity Data (each line item if applicable)	
Total Inpatient Admissions	
Total Inpatient Discharges	
Total Outpatient/Clinic Visits	
Total number of times identified as procedure provider (all procedures)	
Total number of Surgical Procedures	
Avg LOS (all patients for this provider)	

Performance Data		**Current Physician Performance (Data)**	**Peer Specialty Range (if available)**	**Expected Performance (range)**	**Previous Performance**
Patient Care					
For LOS - choose from among top 2 diagnoses for Specialty					
Avg LOS in days for most common diagnosis in this specialty					
Number of wrong side surgeries					
Number of unplanned returns to OR within 7 days w/o death					
Number of Prescribing Error Adverse Drug events (category 6 - 9) wherein practitioner was responsible attending (usually on-call physician) per reporting period					
Number of SSE cases wherein practitioner was attending of record (per reporting period)					
Specialty Specific Indicator per Section/Dept. Chief					
Specialty Specific Indicator per Section/Dept. Chief					
Interpersonal & Communication Skills					
Number of Patient/Family Complaints					
Number of Reported Patient/Family Compliments					
Professionalism					
Number of Peer Complaints					
Number of Peer Compliments					
Systems-based Practice					
Number of months on delinquent medical record list					
Number of months on unsigned verbal order list					
Medical/Clinical Knowledge					
Meets Board Certification Requirement		Yes / No			

Document reviewed by Individual Practitioner Comments:	Signature: Date:
Document reviewed/approved by Section/Department Chief Comments:	Signature: Date:

Expected target met (green)

Needs Follow-up and continued monitoring (yellow)

Below Expected Performance (red)

4.2. Practitioner Health

4.2.1. Impaired Practitioners

An impaired practitioner is one who is unable to practice according to acceptable and prevailing standards of care by reasons of mental illness or physical illness or because of habitual or excessive use or abuse of drugs, alcohol or other substances that impair the ability to practice. It is the policy of the Medical Staff as provided herein below to provide a process whereby a practitioner may self-report their impairment to a member of the Professional Review Committee who can facilitate initiation of a confidential therapeutic and monitoring program. Medical Staff members who fail to self-report and are suspected of being impaired may be investigated and, if the facts warrant, shall be provided with reasonable accommodations and such other assistance as may be legally appropriate. This policy is also to provide a course of action if a practitioner is determined to have an impairment, which, with or without assistance, and or reasonable accommodation, requires that privileges must be restricted, suspended or terminated.

4.2.2. Informal Process

Whenever the professional conduct of any practitioner, including those with temporary privileges suggests a possible health issue, then there shall first be an attempt to resolve the concern informally in accordance with the following procedure.

A. This informal process shall be initiated by the complainant notifying the Vice President of the Medical Staff of the nature of the concern and the basis allegedly supporting it. In the event the Vice President is the involved person, the investigation and report shall be performed by the Medical Staff President. The Vice President may, in his/her discretion, involve other Officers and/or the Chief Medical Officer, to aid in any of the steps described in this section.

B. The Vice President of the Medical Staff shall then meet with the member about whom the concern is raised to discuss the concern and seek a mutually agreeable resolution. This meeting may include the individual who raised the concern at the discretion of the Vice President of the Medical Staff. Part of the Vice President's assessment may include a review of any existing personnel files of the practitioner about whom the concern is raised and/or consultation with the Professional Review Committee as appropriate.

C. At the conclusion of this informal process, the Vice President shall make a recommendation to the Medical Staff President. The Medical Staff President shall confer with the Chief Medical Officer and the Chief Executive Officer as appropriate, before determining a course of action which may include (a) closure of the review for lack of sufficient supportive evidence; (b) a requirement for professional evaluation and/or treatment; (c) such other assistance, counseling, rehabilitative services or reasonable accommodations as may be appropriate under the circumstances; and/or (d) referral to the Formal Process set forth in Article 1.

D. The affected party shall be advised by the Vice President of the Medical Staff of the resolution or course of action determined.

E. The informal process shall be documented. Written documentation shall be maintained in the respective practitioner's file in the Medical Staff Office. If it is determined that there is insufficient merit to the allegation, the written documentation will be forwarded to the Nationwide Children's Hospital Legal Services Department and will be maintained in a privileged and confidential file.

Nationwide Children's Hospital

Columbus, OH

Approval Process for Medical Staff
Ongoing Professional Practice Evaluation Process (OPPE)
And
Focused Professional Practice Evaluation (FPPE)

Data is collected by the Quality Improvement Services Department

Data evaluation forms are forwarded to the Medical Staff Office

The Medical Staff Office will forward evaluation forms to the appropriate department/section chief(s) for review and signature

Department/section chief(s) will discuss OPPE/FPPE evaluation form with respective practitioner

Practitioner will acknowledge OPPE/FPPE evaluation form with his/her signature

Department/section chief(s) will return evaluation forms to the Medical Staff Office. Evaluation forms will be filed in the respective practitioner's quality profile

4.3. Guidelines for Practitioner In-House Service

A. This guideline relates to practitioners who have performed 24 hours of continuous in-house service. Since it is essential for patient safety that effective transitions in care occur, the practitioners who have performed more than 24 hours of continuous service may remain on site to write notes, complete orders, transfer patient care with hand-off to oncoming physicians, and perform other activities that do not involve direct patient care. These practitioners should refrain from performing elective surgical procedures or have any direct clinical responsibility for the subsequent 10 hours, except as set forth in B.

B. In certain circumstances, the practitioner may remain beyond the 24 hours of continuous in-house service to continue to provide care to a single patient or a category of patients. Reasons for such extensions of duty are limited to reasons of required continuity for severely ill or unstable patients or an extremely long and complex surgical procedure, or humanistic attention to the needs of a patient or family or in an emergent situation when no other required specialists are available. Under these circumstances, the practitioner should hand over the care of other patients where another practitioner is available to provide for their continuing care.

C. If a practitioner is believed to be providing direct patient care for more than 24 hours and none of the pressing patient care needs as listed in Section B. apply, then concerned hospital personnel and/or medical staff observing the practitioner working with patients should notify the Chief Medical Officer, or a Medical Staff Officer, or the Administrator-on-Call to assess the situation. If it is confirmed that a practitioner is working beyond 24 hours of continuous in-house service and none of the circumstances set forth in B apply, then he or she should be excused from direct clinical duties for the subsequent 10 hours.