Policy: Clinician Professional Practice Evaluation

Category	QSRP
Policy Number	QSRP 10-10.12
Approval Date	February 2021
Effective Date	February 2021
Supersedes	May 2018

Applicable to

☒ Adult Enterprise ☒ Pediatric Enterprise ☒ Behavioral Health Enterprise

Team Members Performing

☐ All faculty & staff ☐ Faculty & staff providing direct patient care or contact ☐ MD ☐ House Staff ☐ APRN/PA ☐ RN ☐ LPN

☒ Other: MD and all clinicians with clinical privileges

Responsible Committee

☐ Clinical Operations Committee
☐ Clinical Practice Committee
☒ Quality Steering Committee
☐ Infection Prevention Executive Committee
☐ Pharmacy, Therapeutics, and Diagnostics Committee
☐ Health Record Executive Committee
☐ Information Privacy and Security Executive Committee
☐ Medical Center Safety Committee

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I. Purpose:

To promote safe and effective care and to support a culture consistent with VUMC goals, the medical staff engages in ongoing assessment of the performance of clinically privileged individuals through Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE).

II. Policy:

All clinically privileged individuals will undergo ongoing assessment of their performance through Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE). Data from OPPE and

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FPPE will be used by the service chief or the service chief's designee to support privileging decisions.

III. Clinician Professional Practice Evaluation:

A. All clinically privileged individuals participate in Professional Performance Evaluation. Clinically privileged individuals are either undergoing FPPE or OPPE at any point in time.

B. Information from FPPE and OPPE is compiled and used by the service chief or the service chief's designee to support privileging decisions.

IV. Focused Professional Performance Evaluation (FPPE):

A. FPPE is a time-limited process initiated for all clinically privileged individuals: 1) newly appointed to medical or professional staff and granted clinical privileges or approved for new clinical privileges between reappointment cycles; or, 2) who meet predefined triggers suggesting a need for performance monitoring to ensure the delivery of safe, high-quality patient care.

B. FPPE is conducted when the following conditions occur:

1. First 6 months or predefined number of procedures or activities based on the frequency of the procedure or activity selected by clinical service chief or designee;
2. Clinician meets triggers suggesting a difference in performance from group norms or standards; or,
3. Single events necessitating further performance review.

C. Triggers include:

1. Performance on any general competency which appear to differ from group norms or standards;
2. Events potentially detrimental to delivery of patient care or patient/staff safety;
3. Concerns for unethical or illegal behavior; and
4. Actions that appear to be contrary to VUMC Bylaws or disruptive to VUMC operations.

D. The evaluation includes the clinician's ability to practice safe and effective care based on review of <u>practice-specific</u> qualitative and quantitative data covering the six general competencies, including:

1. Patient care;
2. Medical/clinical knowledge;

3. Systems-based practice;
4. Practice-based learning;
5. Interpersonal communication; and
6. Professionalism.

E. Sources of data for FPPE may include:

1. Direct observations
2. PARS/CORS Data
3. Chart reviews or overreads
4. Case lists
5. Outcome databases
6. Simulation
7. Discussion with others involved in care
8. Peer or patient surveys, complaints
9. Note if zero data, the evaluator will need to consider why zero data are available and ensure the clinically privileged individual continues to meet the requirements for the requested privileges.

F. FPPE is performed by a proctor with appropriate experience/knowledge to evaluate assigned by the service chief or designee. The Proctor reviews available data and reports findings to chief or designee. External review may be sought if there is a conflict of interest or the procedure is new to VUMC. At the end of the FPPE, next steps are initiated based on the Proctor and Service Chief's Assessment of adherence to onboarding or monitoring plan, and the clinician's performance at the end of the predefined period, or response to measures implemented to resolve performance issues, and could include:

1. Transition to OPPE;
2. Continue FPPE as is or with additional elements for an additional time-limited period; or
3. Pursue action to limit or revoke privileges as described in Article XIII of the Medical Staff Bylaws.

G. Documentation:

1. Initiation of FPPE is documented in writing with the reasons for the FPPE, the assigned Proctor, the elements of the FPPE, and the time-limited period of review. The presence of FPPE is communicated to Provider Support Services.
2. For routine FPPE initiated for individuals newly appointed to medical or professional staff and granted clinical privileges or approved for new clinical privileges between reappointment cycles, the above information is included with their initial appointment letter.

3. For FPPE initiated for triggers or single events necessitating further performance review, the documentation is provided to the individual by the service chief or designee and communicated to Provider Support Services.
4. Completion of FPPE or need to pursue further action is documented in writing with the results and interpretation of the FPPE data and the plans for next steps (i.e. move to OPPE, continue FPPE as is or with additional evaluation, or other actions). The status of the FPPE is communicated to Provider Support Services.

V. Ongoing Professional Performance Evaluation (OPPE):

A. OPPE is a continual process to evaluate a clinician's practice, identify professional practice trends that impact quality of care and patient safety and to validate on-going competence for existing clinical privileges.

B. OPPE is performed for all clinically privileged individuals who are not on FPPE.

C. OPPE is conducted continuously, and data are compiled and reviewed ~every 6 months (at least three times per credentialing cycle).

D. OPPE is performed by the Service Chief or Designee, who reviews available data and decides to:

1. Continue OPPE;
2. Transition to FPPE; or,
3. Pursue action to limit or revoke privileges in accordance with Article XIII of the Medical Staff Bylaws.

E. OPPE evaluates the clinician's ability to practice safe and effective care based on review of practice-specific qualitative and quantitative data covering the six general competencies. Example metrics are shown in the appendix:

1. Patient care;
2. Medical/clinical knowledge;
3. Systems-based practice;
4. Practice-based learning;
5. Interpersonal communication; and
6. Professionalism.

F. Sources of data for OPPE may include:

1. Direct observations;
2. PARS/CORS data;
3. Chart reviews or overreads;
4. Case lists;
5. Outcome databases;
6. Simulations;
7. Discussions with others involved in care;
8. Peer or patient surveys, complaints;
9. Note if zero data, consider why zero?

G. Triggers for a change in status include:

1. Performance on any general competency which appear to differ from group norms or standards;
2. Events potentially detrimental to delivery of patient care or patient/staff safety;
3. Concerns for unethical or illegal behavior; and
4. Actions that appear to be contrary to VUMC Bylaws or disruptive to VUMC operations.

VI. Documentation:

At the completion of each review cycle, the results of the OPPE review are conveyed to the clinically privileged individual. Provider Support Services is notified that OPPE has been completed and the status.

VII. Use of Clinician Professional Performance Evaluation to Guide Privileging Decisions:

A. At the time of recredentialing, the service chief or the service chief's designee reviews compiled data from OPPE and/or FPPE to support privileging decisions.

B. Failure to successfully complete an FPPE or to participate faithfully in OPPE, may result in corrective action as outlined in Article XIII of VUMC Medical Staff Bylaws.

VIII. Confidentiality:

Access to credentials files is limited to the individuals, committees and boards as outlined in the VUMC Medical Staff Bylaws. All credentialing related committees and professional review processes constitute quality improvement/peer review committees pursuant to state and federal law. These files shall be privileged pursuant to TCA § 63-5-217.

IX. Endorsement:

Quality Steering Committee	January 2021
Medical Center Medical Board	February 2021

X. Approval:

Marilyn Dubree, MSN, RN, NE-BC Executive Chief Nursing Officer, VUMC	2/26/21
C. Wright Pinson, MBA, MD Deputy CEO and Chief Health System Officer, VUMC	2/26/21

XI. References:

American Council on Graduate Medical Education. (2012). Common Program Requirement: General Competencies. Retrieved from http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf.

The Joint Commission, Comprehensive Accreditation and Certification Manual. (2021). Retrieved via Eskind Digital Library, http://library.vanderbilt.edu/biomedical/search.php?letter=j#tab-search-databases, select databases, then search Joint Commission. *Medical Staff Standards* MS.08.01.01; MS.08.01.03

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VUMC Policy Manual. (2021). Retrieved from https://vanderbilt.policytech.com.

Governance Category:
VUMC Medical Staff Bylaws
VUMC Medical Staff Rules and Regulations