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I. PURPOSE

To define the process by which the Medical Staff monitors, evaluates and reports the quality of patient care provided by members of the Medical and Allied Health Staffs to identify opportunities for improvement, improve performance and outcomes of care on an individual and organization-wide basis, and take appropriate privilege action when necessary.

II. AUTHORITY AND RESPONSIBILITY

The Medical Staff and Board of Manager’s of Harris Methodist Southlake Center for Diagnostics & Surgery have the authority and responsibility to monitor and evaluate the quality of patient care through organizational and Medical Staff quality improvement activities. The Medical Staff has a leadership role in organizational improvement activities designed to ensure that the findings of the assessment process are relevant to an individual’s performance. The Medical Staff is responsible for determining the use of information in an ongoing and focused professional practice evaluation process of individual granted clinical privileges. The Quality Review Committee will monitor the overall quality process.

III. DEFINITIONS

A. Quality Review Committee (QRC)


A sub Committee of the Medical Executive Committee, as described in the Harris Methodist Southlake Center for Diagnostics & Surgery policy; Administrative-Peer Review.

B. Focused Professional Practice Evaluation (FPPE)

The process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. Focused professional practice evaluation is time-limited period during which the organization evaluates and determines the practitioner’s professional performance.

C. Ongoing Professional Practice Evaluation (OPPE)

Periodic performance review (twice yearly) of all current staff utilizing established performance indicators referenced in the Administrative-Quality Improvement Plan.

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Professional practice trends that impact the quality of care and patient safety may require intervention by the Medical Staff.

IV. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A. NEW PRIVILEGES

A period of focused review will be conducted for all newly appointed practitioners and all existing practitioners who have been granted NEW privileges.

1. The FPPE plan will be practitioner specific. The plan will include the general elements described for OPPE as well as the specialty-specific indicators and any special medical privilege criteria for those privileges, which he/she has been granted.
2. One or more of the following elements will be utilized for each privilege:
 - a. Mortalities
 - b. Complications
 - c. Readmissions
 - d. Quality of documentation
 - e. Returns to the Operating Room
 - f. Infections
3. Methods for evaluation may include:
 - a. Chart review
 - b. Direct observation
 - c. Statistical review
 - d. Proctoring
 - e. Variance reporting
4. Observation Time Period: will be for the first 3 months and/or until 5 procedures have been evaluated. If fewer than 5 procedures or less than 6 admissions have occurred during the 3 months the observation period will be extended.
5. Final Decision: The results of any negative evaluations will be immediately conveyed to the practitioner.
6. If there is insufficient activity to fulfill the requirements of FPPE, it will be considered that the practitioner has voluntarily relinquished his/her privilege(s).

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B. “PROBLEM PRIVILEGES”


FPPE will be initiated if the Quality Review Committee determines circumstances suggest the possibility of a threat to patient safety or well being. When FPPE (for problem privileges) is to be initiated, the plan for focused evaluation will be conducted by the Quality Review Committee along with any follow-up actions deemed necessary. The need for a FPPE will be conveyed to the practitioner by the Chair of the Medical Staff Quality Review Committee or his/her designee.

1. FPPE may be initiated, upon the following circumstances:
 - a. For a single major event.
 - b. For trends or patterns that significantly and undesirably vary from established patterns of clinical practice, recognized standards or from that of other peers.
 - c. A significant staff or patient complaint.
 - d. When the results of an organizational improvement activity or monitoring function identify a significant deviation from accepted standards of practice.
 - e. A breach in behavioral standards.
 - f. Repeated failure to follow hospital policies or Medical Staff Bylaws, Rules & Regulations (e.g. late to surgery, failure to respond to pages, not allowing a ‘read-back’ process, etc.)
 - g. The Medical Executive Committee will define the standards to be used to assess, measure and evaluate individual performance when the Medical Staff wishes to exceed expected standards or performance.

2. A Peer Review process may be initiated by Quality / Risk Management, the Chief of Staff, a Medical Staff member, the President, as appropriate. Sources for identifying cases for review include, but are not limited to, chart reviews, quality indicators, data from medical staff committees, patient or family complaints and variance report forms. The procedure for this process is defined in the Harris Methodist Southlake Center for Diagnostics & Surgery Administrative – Peer Review Policy.

V. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE):

- A. The Medical Staff will conduct periodic performance review of all current Medical and Allied Health Practitioners staff utilizing performance indicators and specialty-specific indicators. Specific special medical privilege criteria will be utilized as applicable. Information resulting from the OPPE is used to determine whether to continue, limit or revoke any existing privileges or initiate a problem specific focused review. Data will

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be reviewed twice yearly and retrospectively from reappointment to reappointment periods and will be reported to the Medical Executive Committee and the practitioner by Medical Staff Services. Data may be obtained from outside facilities where the practitioner has activity when there is not active participation of privileges during the review period. Zero activity may be used as a determination for reappointment approval.

- B. Information used for an OPPE may be acquired through one of the following:
 1. Chart review
 2. Direct observation
 3. Monitoring of diagnostic and treatment techniques
 4. Discussion with other individuals involved in the care of a patient including consulting physicians, assistants at surgery, nursing and administrative personnel

- C. Relevant information obtained from an OPPE is integrated into performance improvement activities, while preserving it's confidentiality. If there is uncertainty regarding the practitioner's performance, the Medical Staff will follow the course of action defined in the Medical Staff Bylaws, Rules & Regulations and Hospital Policies for further evaluation of the practitioner.