Policy # 1 MS 022	Policy Title: Professional Practice Evaluation DMC Ongoing Professional Practice Evaluation Process and Resolution (OPPE)	Attachment 1 Page 1 of 3 Effective: 2/24/2017

I. Ongoing Professional Practice Evaluation (OPPE)

OPPE is achieved through routine monitoring of current competency for Medical Staff members with hospital privileges through systematic data collection and evaluation. Medical Staff evaluation activities may include multidisciplinary staff and may include, but are not limited to:

a. Development of key indicators to assist in reviewing the quality of care provided by the medical staff. These indicators will be specialty specific and will be developed under the guidance of the Specialist-in-Chiefs and/or site Department Chiefs or their designee.

b. The 6 competency domains of The Accreditation Council for Graduate Medical Education (ACGME):

1. Medical Knowledge – knowledge about established and evolving biomedical, clinical and cognate sciences and the application of this knowledge to patient care.
2. Patient Care – provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.
3. Practice based learning and improvement – investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.
4. Systems based practices – awareness and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
5. Professionalism – commitment to carry out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. Interpersonal and communication skills – interpersonal and communication skills that result in effective information exchange and teaming with patients and their families, and professional associates.

c. Review functions based on Medical Staff established criteria for outlier identification, and unexpected clinical event identification per DMC policy.

d. Screening functions based on performance criteria for:
- Review of operative and other clinical procedures performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner's use of consultants
- Other relevant criteria as determined by the organized medial staff

e. Concurrent quality and risk case identification utilizing established generic screening indicators.

f. Analysis of data and trends for identification of problems or deficiencies associated with the findings.

g. Design of focus studies for further intensive review and investigation as indicated through interactions with Medical Staff Leadership.

h. Participation and facilitation of clinical multidisciplinary process improvement activities and ongoing monitoring of measurement characteristics with review of outlier cases as indicated.

Information used in physician evaluation may be acquired through, but not limited to, the following:
- Periodic Chart and electronic medical record review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Incident reporting and sentinel event data

- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, and nursing and administrative personnel.

II. Process for Ongoing Professional Practice Evaluation -- Medical Staff

1. Ongoing performance evaluation is the responsibility of the Specialist-in-Chief (SIC) of each area.
2. Ongoing performance evaluations should be completed for every physician with active hospital privileges, every eight (8) months. Those physicians who are “members only” of the Medical Staff without active hospital privileges are not included in the OPPE process.
3. Evaluations will consider the ACGME competencies.
4. Metrics are defined by the SIC/department and approved by the medical leadership. Metrics are available on the Medical Affairs section of the DMC Intraweb.
5. In order to facilitate the OPPE completion, Corporate Quality will provide system wide data on individual physician performance. This data may include:
    a. Finance/utilization metrics including volumes, variable cost, and LOS (excess days)
    b. Mortality data
    c. Readmission data
    d. Core Measures performance
    e. Other quality measures performance as available
    f. Medical Records metrics including discharge summary completion, completion of post operative dictations and quality of H&P (where available)
    g. Peer review cases in the peer review data base
    h. Incident data (SRM)
6. Individual departments may identify their own data sources to be used in addition to system data.
7. System data will be placed in a Quality share drive, with password protected files for each SIC. Each SIC can thus access only his/her own files. Data is in “read only” version and cannot be changed. However it may be copied and shared as deemed necessary by the SIC for the completion of the OPPE.
8. The SIC is responsible for ensuring OPPE is completed on each physician in that area, at all hospitals throughout the DMC, utilizing data and department-defined metrics as described above.
9. The SIC may delegate responsibility for OPPE to the site chief and/or department advisory board.
10. An OPPE form is to be completed. This may be the DMC system OPPE form, or a department specific form. Departmental forms must include decision section with options to “continue, limit or revoke privileges” and include decision maker name and signature.
11. OPPE forms will be sent to Corporate Medical Affairs which will keep them as part of a practitioner’s quality file (separate from the credentialing file). SICs may choose to keep individual files as well.
12. Ongoing Professional Practice Evaluations will be considered in the recredentialing process for each physician, and will be provided by Corporate Medical Affairs.

III. Process for Ongoing Professional Practice Evaluation -- Allied Health Professionals

1. Ongoing performance evaluation is the responsibility of the Specialist-in-Chief (SIC) of each area.
2. Ongoing performance evaluations should be completed for every practitioner with active hospital privileges every 8 months.
3. Metrics are defined by the SIC/department and approved by the medical leadership. Metrics are available on the Medical Affairs section of the DMC intraweb.
4. In order to facilitate the OPPE completion, Corporate Quality will provide system wide data on individual practitioner’s performance. This data will include:
    - Completed H/P/BAN/Consults
    - Discharge Med Rec w/in 12hrs of DC
    - Depart w/in 90min of DC
    - Core Measures report
    - Use of Blood Cons Criteria

- % of 1unit PRBC in NAB
- % VO/PO co signed in 24 hrs
- % SCIP order sets
- % Completion of Imm Post Op note

5. Individual departments may identify their own data sources to be used in addition to system data.
6. System data will be placed in a Quality Share Drive, with password protected files for each SIC/designee. Each SIC can thus access only his/her own files. Data is in “read only” version and cannot be changed. However it may be copied and shared as deemed necessary by the SIC for the completion of the OPPE. This data must be available to a surveyor to validate the evaluations--it cannot be just an evaluation, but MUST include data. It must also be dated to show the time period in which the data was pulled.
7. The SIC is responsible for ensuring that an OPPE is complete on each practitioner in their area, at all hospitals throughout the DMC, utilizing data and department-defined metrics as described above.
8. The SIC may delegate responsibility for the OPPE to the site chief and/or Department Advisory Committee. All OPPEs must be completed within 30 days of the due date. If it is not completed in this time frame, a second request will be sent to the Sponsoring Physician and to the AHP. The AHP’s privileges will be suspended 60 days after the due date if the OPPE remains incomplete.
9. An OPPE form is to be completed. This will be a DMC system OPPE form, or a department specific form (if applicable). The form must include a recommendation of whether to continue, limit or revoke privileges.
10. OPPE/FPPE’s and supporting documents MUST be kept in the practitioner’s file. The documentation is then forwarded to Corporate Medical Affairs and uploaded in ECHO and must be readily available for any regulatory survey as required.
11. Ongoing Professional Practice evaluations will be considered in the recredentialing process for each practitioner.

Policy # 1 MS 022	Policy Title: Professional Practice Evaluation DMC Focused Professional Practice Evaluation Process and Resolution (FPPE)	Attachment 2 Page 1 of 2 Effective: 2/24/2017

The Focused Professional Practice Evaluation is required the following circumstances:

A. For new members of the Medical Staff.
B. When a member of the Medical Staff requests new procedures or privileges that he/she has not previously performed at our institutions.
C. When a question arises regarding a currently privileged practitioner's ability to perform safe, high quality patient care.

Resolution

a. It is the responsibility of the member to have the FPPE Completion Form completed with the Chief of Service's signature and returned to Corporate Medical Affairs for inclusion in the member's file for consideration at the time of reappointment.
b. Based on the results of the FPPE, the Chief of Service may wish to develop a performance improvement plan or referral to the SIC and Advisory committee for further review.
c. A signed FPPE Completion should be sent to The Corporate Medical Affairs office with ALL supporting documentation within 6 months and Follow up with the provisional member at 6 months if the Completion Form has not been turned in.
d. The FPPE must be completed within 6 months
e. The Corporate Medical Affairs office will follow up with the member at six (6) months if the Completion Form has not been turned in.

A. New Members of the Medical Staff

At the time of the final approval of the applicant for membership on the Medical Staff, the new member will be notified in the appointment letter that a Focused Professional Practice Review (FPPE) of his/her performance will be required within six (6) months. The appointment letter, with a copy of the FPPE policy, a copy of the FPPE completion form, and the approved scope of privileges will also indicate that the new member will need to make an appointment with his/her Chief of Service at this time to develop the FPPE.

a. The FPPE should be organized by the Chief of Service of the member's primary hospital under direction of the Specialist-in-Chief. The Chief of Service, another designated physician, an ad hoc committee or an external peer review source can perform the review.
b. The FPPE can be done by chart review, outcome data review, or proctoring, and may include discussion with peers. This may be prospective, concurrent or retrospective. The FPPE must be done within the first 6 months of appointment.
c. The FPPE must address the provider's scope of approved privileges across all sites of practice and must include a review of at least five (5) patient charts, or more if specified on the Delineation of Privileges form.
d. If this was a Category 2 applicant, the Chief Medical Officer will correspond directly with the Member's Chief of Service and outline the Category 2 issue so that it can will be addressed in the FPPE.

B. New Privileges – Physicians Currently On Staff

The FPPE should be developed by the Chief of Service, under the direction of the Specialist in Chief, of the physician's primary hospital following steps outlined in Procedure a through c as for New Applicants. If there is concern about the results of the FPPE, a performance improvement plan can be developed or referral to the SIC and Advisory committee for further review.

a. Approved criteria exist for the procedure/privilege requested
b. There has been documentation of the training and experience of the physician in performing this procedure/privilege.
c. There has been approval by the Medical Staff for this physician to perform this procedure/privilege.
d. At the time of the final approval of the new privileges, the member will be notified in the approval letter that a Focused Professional Practice Review (FPPE) of his/her performance will be required within six (6) months. The approval letter, with a copy of the FPPE policy, a copy of the FPPE completion

form, and the approved privileges, will also indicate that the new member will need to make an appointment with his/her Chief of Service at this time to develop the FPPE.

e. The FPPE should be developed by the Chief of Service, under the direction of the Specialist-in-Chief of the physician's primary hospital as outlined in Procedure Sections b-d for New Applicants and the FPPE Completion Form must be returned to Corporate Medical Affairs for inclusion in the member's file. If there is concern about the results of the FPPE, a performance improvement plan can be developed or a referral should be made to the Site Chief, SIC, and/or Advisory committee for further review.

C. Competence Concerns about Medical Staff Members as Triggered by the Ongoing Professional Practice Evaluation (OPPE) or Other Triggers

1. When required
   a. Medical Staff Peer Review – Concerns about results of on-going Peer Review by the SIC or Chief of Service at the time of Category 1 reappointment review or the SIC and Advisory committee or the Chief of Service at the time of Category 2 reappointment and interval reviews.
   b. Concern about results of on-going peer review at any time by the Department Peer Review Committee, Service Chief, MSOC, SIC and Advisory Committee, Credentials Committee or Medical Executive Committee.
   c. The FPPE must be completed within 6 months

2. Procedure and Resolution: The FPPE should be developed by the Chief of Service of the primary hospital, under the direction of the Specialist-in-Chief, as indicated under the Procedure Sections b-d under New Applicants. The results will be returned to the body that requested the FPPE.

Policy # 1 MS 022	Policy Title: Professional Practice Evaluation DMC Focused Professional Practice Evaluation Completion Form (FPPE)	Attachment 2A Page 1 of 4 Effective: 2/24/2017

Medical Staff member: **_#Name_FML_T#__** Primary Hospital**: #PrimeHospT#**

Date Privileges Granted for ***New Member to Medical Staff***: **#F_ApptDt:Afac_cd='CORP'#**

Purpose of Focused Professional Practice Evaluation:

☐ Evaluation for Competency of Granted Privileges for New Practitioner.

☐ Evaluation for Competency of Granted Additional Privileges.

☐ Evaluation for Concern:

____

FPPE Method (check all that apply)*:

☐ Chart review **(Mandatory)**

☐ Outcome data review

☐ Proctoring **(Attach proctoring forms)**

☐ Discussion with peers **(List peer names, titles)**

____

____

____

☐ Other

____

***The FPPE must evaluate the provider's approved privileges across all sites of practice.**

The results of the evaluation were:

☐ **Satisfactory**

☐ **Unsatisfactory (for the following reasons):**

____

____

Recommendation:

☐ Continue with New Privileges
☐ Move to Membership Only
☐ Other: Limit Privileges
☐ Other: Revoke Privileges
☐ Other: Extend FPPE Period for ___________________ (maximum of 6 months allowed)

Comments:

Policy # 1 MS 022	Policy Title: Professional Practice Evaluation DMC Focused Professional Practice Evaluation Completion Form (FPPE)	Attachment 2A Page 2 of 4 Effective: 2/24/2017

____

____

Hospital: ☐ CHM ☐ DRH ☐ HAR ☐ HUT ☐ HVH ☐ RIM ☐ SNG

Printed name of person performing review: ______________________________

Signature below attests that the supporting data for this FPPE has been reviewed. Chart FIN numbers and Privilege/Procedure are listed on next page.

Signature/Date of person performing review: ______________________________
Chief of Service Signature/Date: ______________________________

#Name_FML_T# / #F_Dept/Sec:Afac_cd='CORP'#
APPROVED PRIVILEGES
#F_ApptDt:Afac_cd='CORP'#

#Priv_1_Y:Afac_cd<>'KCC' and sch_type='CU'#
#PrivComnt1#
#PrivComnt2#

#Name_FML_T#

***The FPPE must evaluate the provider's approved privileges across all sites of practice.**		
Chart Review (minimum of 5 or number specified on Delineation of Privileges form)		
FIN	**Privilege/Procedure**	**Outcome**

Policy # 1 MS 022	Policy Title: Professional Practice Evaluation DMC Medical Staff Peer Review Process	Attachment 3 Page 1 of 2 Effective: 2/24/2017

Medical Staff Peer Review is the periodic review performed for individual cases where an issue has been identified.

Peer Review Definitions:

Classifications:		Description
Class 0	No adverse effect	'No harm' to patient, monitoring/intervention is minimal or not indicated
Class I	Minimal adverse effect	Temporary effect on patient; intervention may or may not be instituted.
Class II	Moderate adverse effect	Temporary or reversible effect on patient; minor to major intervention is instituted and may require higher level of care such as telemetry/critical care, and prolonged hospitalization
Class III	Severe adverse effect	Near death event (e.g. anaphylaxis or cardiac arrest) Permanent harm to patient, requiring major intervention
Class IV	Death	Event resulted in patient death

Review Process

- Upon identification of concerns related to a trend or event, the concern identified will be documented on the Medical Staff Peer Review form (See attachment 2), and directed to the appointed department peer review physician or committee.
- The peer physician and/or committee will review the patient record and may request further information from the involved physician. This request maybe made by direct contact or by use of the Peer Review Referral Letter. See enclosed example.
- The involved physician should respond to the concerns in writing and/or discuss the case with the physician peer group.
- If the issue is resolved upon review of the case, the Medical Staff Peer Review form is completed and returned to the site Clinical/Quality Improvement Department and entered in the Peer Review Database for tracking and trending purposes. If the outcome of the review is preventable/possibly preventable, the involved physician should be notified by use of the Case Review Decision Letter (see enclosed example).
- If the involved physician fails to respond to the inquiry within 15 days, this will be so recorded and the peer review process will continue.
- If the issue is resolved by a department committee, the Medical Staff Peer Review form is completed and returned to the site Clinical/Quality Improvement Department and entered into the Peer Review Database for tracking and trending purposes. If the issue is resolved by a single physician peer, the Medical Staff Peer Review Form is completed and returned to the Chief of Staff for a secondary review. If both are in agreement, the Medical Staff Peer Review form is returned to the site Clinical Quality/Improvement Department and entered into the Peer Review Database for tracking and trending purposes. If there is disagreement the case is referred to the MSOC for direction.
- If after the Department Peer Review Committee has considered the physicians response and still believes the issue is Preventable/Possibly Preventable, the medical staff peer review form is returned to the site Clinical Quality/Improvement Department and entered into the Peer Review Data Base for tracking and trending purposes. If the peer review decision has been made by a single physician and was considered to be Preventable/Possibly Preventable, it is referred to the VPMA, who after assuring that the medical staff peer review form is complete will present a summary of it to the MSOC or a designated peer review committee for their oversight review. If the MSOC agrees with the review, the medical staff peer review form is returned to the site Clinical Quality/Improvement Department and entered into the Peer Review Data Base for tracking and trending purposes. Both peer review committee chairs and the VPMA, or their designee, should assure that the physician has had input into the decision regarding a Preventable/Possibly Preventable event and that the physician is notified of the final outcome. They also,

with the Service Chief should monitor any performance improvement plans that have been set up. All Preventable/Possibly Preventable class III and IV decisions should be presented to the MSOC by the VPMA for oversight review.

- The total peer review process will be completed within 60 days of case identification unless the VPMA of the hospital grants an extension.
- All referrals to the Medical Staff for Peer Review will be, when complete, entered into the Peer Review Data Base for tracking and trending.
- Any practitioner reaching a threshold of peer review results, requires review. Their file may be considered a Category 2* file at the time of reappointment based on review findings. The remaining files with peer review results will continue to be reviewed as Category 1*. Core thresholds for review will include any Preventable/Possibly Preventable Class II, III or IV results that reach 3 in number.
- If a practitioner reaches these thresholds, the practice of that person will be reviewed by the Department Advisory Committee. The committee with final approval by the SIC, will determine what, if any, further action is necessary. This may include a recommendation for focused practice review, a recommendation for Category 2 reappointment status, other or no remediation.

If the Advisory Committee recommends reappointment, the file will be processed as a Category 1. If the Advisory Committee recommends a change in membership or privileges the file will remain a Category 2 and be referred to the DMC Credentials Committee. All category 2 files should be identified only by the Physician number when presented to the Medical Executive committee and the Joint Conference committee.

If Peer review results reach these thresholds between the two reappointment dates, the SIC or their designee will be notified so that a review by the Department advisory committee can be done. The results of this review will be shared with the Physician and the Chief of Service.

The Department Advisory Committee at either the reappointment review or interval review may request from the Chief of Service a Focused Professional Practice Evaluation of the physician's practice if more information is needed to reach a final recommendation or a Performance Improvement Plan, which may include a recommendation that a practitioner be referred for continuing medical education, if improvement in the physician's practice management is deemed necessary.

Due Process/Appeal

- In the event the determination of the peer review is deemed objectionable by the reviewed physician; an appeal is available via the Clinical Departmental Advisory Committee.
- All reviews and actions must conform to the "due process rules" of the DMC Medical Staff Bylaws. When actions are contemplated; the DMC Chief Compliance Officer, as counsel to the hospitals, shall be included in the process and shall be sought for advice as needed. This ensures that due process is provided for physicians and that the interests of the DMC hospital and Medical Staff are represented. (See DMC Medical Staff Bylaws).

External Review

Circumstances requiring external peer review are outlined in the DMC Medical Staff Bylaws and include, but are not limited to:

- Ambiguous or conflicting recommendation from internal reviewers or medical staff committee or when reviewers or committee cannot reach consensus for a particular recommendation.
- When no one on the medical staff with expertise in the same specialty as the physician under review is available.

* Refer to 1 MS 018 Credentialing of Medical Staff or Allied Health Professionals Fast Track Credentialing for definitions of Category 1 and Category 2.

- ☐ CHM
- ☐ DRH
- ☐ Harper
- ☐ Hutzel
- ☐ HVS
- ☐ Karmanos
- ☐ MIOSH
- ☐ RIM
- ☐ SGH

MEDICAL STAFF PEER REVIEW FORM

Tracking Report # ____________

Referred by:	Title:	Date:	Time:
Patient Last Name:	First Name:	Acct #:	
Med Record #:	Admit date:	Discharge Date:	Physician:

Concern(s): *(check below)*

✓	Screens	✓	Screens
	Autopsy Discrepancy		Surgical Case Review /Tissue Discrepancy
	Blood Usage Review		Unexpected Clinical Event
	Drug Usage Review/Adverse Drug Event		Utilization Management Issue
	Patient Management Issue		Other (specify):
	Patient/Family Concern		Incident Report # (if applicable):

Pertinent Information:

Signature:____________________ Title:____________________ Date:____________

Preliminary Review by: ☐ QI Physician ☐ Dept Chief/Section Director ☐ Ad Hoc Committee ☐ Other (specify)

Signature:____________________ Title:____________________ Date:____________

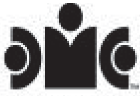
Action(s)Taken:

☐	None necessary	Date:	☐	Specialist in Chief referral	Date:
☐	Attending/involved physician referral	Date:	☐	Risk Management referral	Date:
☐	Department/Section Chief referral	Date:	☐	Education	Date:
☐	Ad Hoc Peer Review referral	Date:	☐	Other referral:	Date:

Reviewer Signature:____________________ Title:____________________ Date:____________

Review By:		Classification	Outcome
Date:	QI Physician	☐ Class 0 - No adverse effect	☐ Not preventable (Approved)
Date:	Ad Hoc Committee	☐ Class I - Minimal adverse effect	
Date:	Attending/Involved Physician	☐ Class II - Moderate adverse effect	☐ Possibly preventable
Date:	Department/Section Chief	☐ Class III - Severe adverse effect	
Date:	Department Peer Review Committee		
Date:	Specialist in Chief	☐ Class IV - Death	☐ Preventable (Not Approved)
Date:	External Review		

Clinical Improvement/mce Origination date: 2/10/04 This report is a confidential professional/peer review and quality improvement document of the Detroit Medical Center. It is protected from disclosure pursuant to one or more of the provisions of MCL 331.531, MCL 331.533, MCL 333.20175, MCL 333.21513, MCL 333.21515, and MCL 330.1143a and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited 1 MS 022 - Attachment 3A



MEDICAL STAFF PEER REVIEW FORM

Concerns listed on other side. Review and provide response below. Once completed, return this form to ________________________________ within 14 days.

RESPONSE TO PRELIMINARY REVIEW:

By: ☐ Attending/Involved Physician ☐ Dept Chief/Section Director ☐ Ad Hoc Committee ☐ Other **(specify)**

Signature:________________________________ Title:________________________________ Date:____________

Recommendations based on Response:

Made by**:** ☐ QI Physician ☐ Dept Chief/Section Director ☐ Ad Hoc Committee ☐ Other **(specify)**

Signature:
________________________________Date:__________

☐ Response Accepted (return to CI Department) ☐ Refer to Ad Hoc Peer review

Additional Review and Recommendations:

Made by: ☐ QI Physician ☐ Dept Chief/Section Director ☐ Ad Hoc Committee ☐ Other (specify)

Signature: ______________________________
Date:__________

☐ Response Accepted (return to CI Department) ☐ Refer to MEC

When complete, return this form to your site Clinical/Quality Improvement Department

Clinical Improvement/mce Origination date: 2/10/04 This report is a confidential professional/peer review and quality improvement document of the Detroit Medical Center. It is protected from disclosure pursuant to one or more of the provisions of MCL 331.531, MCL 331.533, MCL 333.20175, MCL 333.21513, MCL 333.21515, and MCL 330.1143a and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited - 1 MS 022 Attachment 3A

CONFIDENTIAL

DMC MEDICAL STAFF
PEER REVIEW COMMUNICATION

Peer Review Referral Letter

Date______________________

Dear Dr__________________:

The following concern has been presented to the Department of _______________ for Peer Review. I would appreciate your input, so we may be better informed about the issue.

The concern was regarding patient number ____________________, whose chart will be available in the record room for your review. The concern was:
____
____
____

The committee would appreciate your input regarding this issue. Please respond within two weeks so we can complete this review in a timely manner. If we do not hear from you in that time frame, the committee will continue its review.

Department of_________________, Peer Reviewer ____________________________.

Dear Peer Reviewer,
My Response is:
____
____
__________________________________.

You may respond by calling the reviewing physician directly or respond by mail with an envelope marked **CONFIDENTIAL**.

This is a confidential professional/peer review and quality improvement document of the DMC. It is protected from disclosure pursuant to one or more of the provisions of MCL 331.531, MCL 331.533, MCL 333.20175, MCL 333.21513, MCL 333.21515 and MCL330.1143a and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited. If you received this transmission in error, immediately contact the sender and destroy the material in its entirety, whether in electronic or hard copy format

CONFIDENTIAL

DMC MEDICAL STAFF
PEER REVIEW COMMUNICATION

Case Review Decision Letter – Preventable/Possibly Preventable Result

Date:____________________

Dear Dr_______________:

The Peer Review Committee of the Department of ______________________/MSOC of ___________________Hospital has completed the review of the case in which you were either an Attending or Consulting Physician. Patient's number:___________________________________.

The concern was
____
____
____
____.

Upon review of the case, the committee has determined that this was a Preventable/Possibly Preventable result and has determined also that this resulted in the following classification:

Class 0 - no adverse effect
Class I - minimal adverse effect
Class II - moderate adverse effect
Class III - Severe adverse effect
Class IV- Death

If you wish to appeal this decision, please notify me so I can refer it to the Specialist-in-Chief and Advisory Committee of your department.

____

Chairman, Peer Review Committee/MSOC

This is a confidential professional/peer review and quality improvement document of the DMC. It is protected from disclosure pursuant to one or more of the provisions of MCL 331.531, MCL 331.533, MCL 333.20175, MCL 333.21513, MCL 333.21515 and MCL330.1143a and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited. If you received this transmission in error, immediately contact the sender and destroy the material in its entirety, whether in electronic or hard copy format

Title:	Professional Practice Evaluation	Page 1 of 4
Policy No:	1 MS 022	Effective Date: 02/24/2017

I. SCOPE

All members of the DMC Medical Staff/AHP, Clinical Department Chiefs, Specialist-in-Chiefs, Chief Medical Officers, Chiefs-of-Staff.

II. OBJECTIVE

To provide an initial and ongoing, organized and systematic mechanism for Medical Staff/AHP evaluation, including the Focused and Ongoing Professional Practice Evaluation and Peer Review, and to promote the continuous assessment, measurement, and improvement of patient care. These processes comprehensively evaluate the medical care provided by practitioners to patients.

III. DEFINITIONS

Medical Staff: The Licensed Independent Medical Staff of the Detroit Medical Center. These policies do not apply to graduate medical staff.

Allied Health Professional (AHP): Included are individuals who hold advance license through the state of Michigan.

Focused Professional Practice Evaluation (FPPE): The time-limited evaluation of privilege-specific competence of a practitioner who does not have fully documented evidence of performing the requested privilege at the organization.

Ongoing Professional Practice Evaluation (OPPE): The continuous and ongoing process of reviewing and evaluating practitioner performance, based on department-defined specific metrics.

Peer Review: The incident-specific periodic review of medical staff practice performed for individual cases where an issue has been identified.

Incident Reporting: The process for reporting any adverse incidents within the Detroit Medical Center. Any employee may report an incident through this on-line process or by contacting the Compliance Hotline.

IV. POLICY

The evaluation process is clearly defined in writing by each department and approved by the Medical Executive Committee. Practitioner evaluation activities will be performed:

1. To identify and address professional practice issues that impact the quality of care and patient safety within the organization and make recommendations and referrals to appropriate groups and committees.
2. To analyze and trend quality assessment data.
3. To track the effectiveness of corrective actions taken in response to quality improvement recommendations.
4. To reduce the risk of medical errors by identifying adverse patient occurrences or other incidents where corrective intervention may be feasible.
5. To provide objective Performance Improvement data that is used as an integral measurement of the quality practitioner profile, which may be used in the credentialing/recredentialing process and implement changes to improve performance.
6. The DMC shall indemnify via its Risk Management program and Directors/Officers policy for those members of the Medical Staff/AHP who participate in the Peer Review Process as described in this policy.

V. PROVISIONS

I. Ongoing Professional Practice Evaluation (OPPE):

1. The purpose of the Ongoing Professional Practice Evaluation is to allow the organized Medical Staff/AHP to concurrently identify professional practice trends that impact the quality of care and patient safety within the organization. OPPE is achieved through routine

monitoring of current competency for Medical Staff/AHP members with hospital privileges through systematic data collection and evaluation.
2. The OPPE information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of reappointment.
3. OPPE is the responsibility of the Specialist-in-Chief or his/her designee. Any evaluation referencing quality of care concerns shall be acted upon by the Specialist-in-Chief and/or through the departmental advisory committee.
4. The Specialist-in-Chief is responsible for clearly defining the process and type of data to be collected for his/her department, and for ensuring that ongoing evaluation is completed in a timely manner every eight (8) months.
5. Clinical Quality and Corporate Medical Affairs will provide support to Medical Staff/AHP evaluation activities.
6. Relevant information obtained from the evaluation process is integrated into performance improvement activities.

II. Focused Professional Practice Evaluation (FPPE):
1. The FPPE is required in the following circumstances and are seen as triggers for FPPEs:
   - for new members of the Medical Staff/AHP.
   - when a member of the Medical Staff/AHP requests new procedures or privileges that he/she has not previously performed at our institutions.
   - when a question arises regarding a currently privileged practitioner's ability to perform safe, high quality patient care.
2. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance.
3. Each department defines and documents its own performance monitoring process which includes:
   a. Specific performance elements that are to be monitored
   b. Number of cases or length of time or both to complete monitoring plan
   c. Practitioners assigned to perform monitoring or proctoring
   d. Description of how the results of monitoring and any recommendations will be provided to the appropriate monitoring body.
   e. Circumstances under which monitoring by an external source is required.
   f. Criteria for extending the evaluation period.

   The Specialist-in-Chief will establish a plan on a case by case basis when focused evaluation has been recommended as a result of peer review.
4. In the event the FPPE requirements are not met, the SIC will decide whether the practitioner should continue to hold privileges at the DMC facilities. Recommendations may include:
   a. A one-time extension of FPPE period for six (6) months.
   b. Practitioner change to Membership Only--no clinical privileges.
   c. Practitioner requested to relinquish any privileges not performed during the FPPE period.

III. Low Volume Providers:
At each review point, the Medical Advisory Committee will use data, however limited, to determine whether to continue, limit, or revoke any existing privileges. At the two year reappointment if the Medical Advisory Committee determines it has insufficient practitioner specific data, it will obtain and evaluate peer recommendations. A recommendation(s) from peers (appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant) reflects a basis for recommending the granting of privileges. Ideally, the peer recommendation should be obtained from a member of the medical staff. Sources for peer recommendations may include the following:

- An organization performance improvement committee, the majority of whose members are the applicant¹s peers

- A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant¹s professional performance and competence
- A department or major clinical service chairperson who is a peer
- The medical staff executive committee

Peer recommendations include the following information:

- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant¹s ability to practice.

If the Medical Staff member's volume is insufficient to be evaluated and peer evaluations cannot be obtained, he/she will be given one year to increase activity. If volume is still insufficient after one year, the Member Staff member will be given the option of changing to the Membership Only status which obviates the need for OPPE or voluntarily relinquishing his/her privileges.

IV. Medical Staff Peer Review: The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence.

1. It is the responsibility of the Specialist in Chief to clearly define the process for collecting, investigating and addressing clinical practice concerns.
2. Medical Staff Peer Review reflects periodic review performed for individual cases where an issue has been identified. Review may be initiated for, but is not restricted to:
   - Singular event leading to an unexpected adverse outcome.
   - Case identified via generic screen or medical staff functions.
   - Clinical specialty defined screens.
   - Variance in expected performance rate - aggregate specialty level of performance.
   - Specified trend or rate change over time.
   - Patient or family concerns/complaints.
   - Significant departure from established patterns of clinical practice.
3. The peer review process contains the following characteristics:
   - Consistent: Peer review is conducted according to defined procedures for all cases meeting the DMC Medical staff definition of reviewable circumstances. (see Attachment 2)
   - Timely: The total peer review process will be completed within 60 days of case identification, unless the VPMA grants an extension.
   - Defensible: The conclusions reached through the process are supported by a rationale that specifically addresses the issues for which the peer review was conducted, including, as appropriate, reference to the literature and relevant clinical practice guidelines.
   - Balanced: Minority opinions and views of the practitioner under review are considered and recorded.
   - Useful: The results of peer review activities are considered in practitioner-specific credentialing and privileging decisions and, as appropriate, in the performance improvement activities of the DMC as outlined in the DMC Medical Staff Bylaws.
   - Ongoing: Peer review conclusions are tracked and trended over time, and actions taken based on peer review conclusions are monitored for effectiveness.
4. Whenever a system issue or an opportunity for improvement in system processes is uncovered during the course of peer review; that opportunity shall be reported to the site LPICC who shall, upon concurrence,

refer the matter to the site Quality department for the implementation of appropriate improvement activities.

V. CONFIDENTIALITY

To continue to fulfill the DMC commitment to medical safety, the committees must be allowed to review and evaluate medical safety information in a confidential manner. To effectively evaluate medical safety practices, confidentiality must be maintained in order to enable the committees to provide constructive recommendations without the fear of public disclosure.

Records, data, and knowledge collected by or for the committees for their review purposes, including committee minutes, reports, and information provided for or by legal council, shall be confidential and maintained in a confidential manner. They are protected from disclosure pursuant to one or more of the provisions of MCL 331.531, MCL 331.533, MCL 33.20175, MCL 333. 21513, MCL 333.21515, and MCL 330.1143a and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited.

ATTACHMENTS

Attachment 1: Ongoing Professional Practice Evaluation Process and Resolution (OPPE)
Attachment 2: Focused Professional Practice Evaluation Process and Resolution (FPPE)
Attachment 2A: Focused Professional Practice Evaluation Completion Form
Attachment 3: Medical Staff Peer Review Process
Attachment 3A: Medical Staff Peer Review Form
Attachment 3B: Peer Review Referral Letter
Attachment 3C: Case Review Decision Letter

VI. ADMINISTRATIVE RESPONSIBILITY

The President of the Medical Staff has responsibility and authorization for enforcement, interpretation of, or exception to this policy.

APPROVAL

This policy has been approved and is duly authorized by Detroit Medical Center, Children's Hospital of Michigan, Detroit Receiving Hospital, Harper/Hutzel Hospital, Huron Valley-Sinai Hospital, Rehabilitation Institute of Michigan, and Sinai-Grace Hospital. The posting of the policy on the DMC intranet signifies that is in full force and effect.

KEY Search Words

THIS POLICY: is/has been: (check one)

	NEW		REVIEWED	✓	REVISED*

CHANGES/REVISIONS: List Changes Here

- Added language regarding extension of FPPE and OPPE periods
- Realigned attachments

Supersedes	July 2016		Next Review Date	February 2019
Origination Date	October 2007	History - Review/Revision Dates	October 2007 (1 MS 022); February 2008 (1 MS 034); August 2009 (1 MS 022); November 2014 (1 MS 022); February 2015 (1 MS 022); August 2015 (1 MS 022); February 2016 (1 MS 022); July 2016 (1 MS 022)	
Related Tenet Policy (ies) #'s				
Name of Committee / Title of person(s) responsible for this policy's review and approval process		*Corporate Director, CVO/Corporate Medical Affairs*		

Sponsor: CMO, SVP/CQO