

<b>This policy applies to:</b> <input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i> <i>Lucile Packard Children's Hospital</i>	<b>Date Written or Last Revision:</b> April 2010
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**I. PURPOSE**

To ensure that the Medical Staff assesses the ongoing professional practice and competence of its members, conducts professional practice evaluation, and uses the results of such assessments and evaluations to improve professional competency, practice, and the system of care. This attention to the care patterns of individual practitioners is also considered an integral component of our ongoing efforts to evaluate and improve performance of clinical groups and enterprise-based systems of care.

Goals:

- a) Monitor practice and performance to identify improvement opportunities for both individuals and systems of care
- b) Monitor for significant trends in performance by analyzing aggregate data and case findings
- c) Ensure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and helpful

**II. POLICY STATEMENT**

It is the policy of Stanford Hospital and Clinics (SHC) to comply with statutory and regulatory requirements regarding Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE). This policy replaces the policy titled “Medical Staff Quality Assurance and Improvement Activities by Each Service”. The findings of the committees defined in this policy (e.g., Professional Practice Evaluation Committees and the Care Improvement Committee) will be included in the information used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff and on an ongoing basis as appropriate. These committees’ findings will also be forwarded (with safeguards to ensure confidentiality of individual practitioners) to the appropriate venue for potential system improvements.

**III. STATEMENT OF PRINCIPLES**

To err is human. Therefore, humans delivering health care will occasionally make errors, and simple human error does not necessarily indicate substandard care or a substandard caregiver. However, in a Fair and Just Culture we are all responsible for continually identifying and implementing means of minimizing the effects of human fallibility on the care of our patients and for attempting always to further improve the care provided to our patients.

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Except in cases of clearly unacceptable care, the Medical Staff organization's primary goal is to support fellow Medical Staff members in their ongoing efforts to improve their own quality of care; equally importantly we aim to assist in identifying and encouraging systematic improvements in our care processes, always with the goal of improving the overall quality of care at SHC.

#### IV. DEFINITIONS

##### A. Professional Practice Evaluation Committee (PPEC)

1. A PPEC is a peer care review committee authorized by the Care Improvement Committee (CIC) to pursue the quality improvement goals outlined in this policy.
2. The CIC is designated as the primary PPEC and is ultimately accountable to the Medical Executive Committee (MEC) and the SHC Board of Directors for oversight of the professional practice evaluation process. Services, divisions, and/or interdisciplinary groups may form PPEC's when approved by CIC and MEC.

##### B. Ongoing Professional Practice Evaluation (OPPE)

1. OPPE is a process which allows the Medical Staff to identify professional practice trends and systems issues that may affect quality of care and patient safety. The program includes:
  - 1) The evaluation of systems and processes: identification of issues which may impair optimal provision of care or which do not adequately protect the care process against foreseeable human error.
  - 2) The evaluation of an individual practitioner's professional performance, including opportunities to improve care based on recognized standards.
  - 3) Professional practice evaluation is conducted using multiple sources of information, including the review of individual cases, the review of aggregate data (including rate comparisons against established benchmarks or norms), compliance with clinical standards, Bylaws, Rules and Regulations of the Medical Staff and relevant hospital policies.

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- 4) Individual evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care. The Service Chief is provided information on a regular basis as part of OPPE. This information allows him/her to address performance on an on-going basis and to provide feedback to individual medical staff members as appropriate.

C. Focused Professional Practice Evaluation (FPPE)

1. FPPE is a process whereby the Medical Staff more closely evaluates the competency and professional performance of a practitioner. FPPE is not considered a formal Medical Staff investigation, and is not subject to regulations afforded in the investigation process.
  - a. The proctoring program is a component of FPPE (see Proctoring policy).
  - b. FPPE is used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

D. Care Ratings: Practitioner

1. Care Appropriate: Despite a complication (or some other question about the quality of care), it is determined that a majority of peers may have responded similarly under similar circumstances (substitution test). No clear deviation from our standards.
2. Human Error (Practitioner Care Improvement Opportunity): Care which involves simple errors of diagnosis, treatment or judgment by the index physician. May include instances where a practitioner has drifted into a practice pattern which may increase the likelihood of human error and needs coaching and/or education to correct this.

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3. **At Risk Behavior (Inappropriate Care):** Care which as determined by the reviewing committee, raises concerns whether the practitioner might require education and/or coaching to prevent recurrence.
4. **Reckless Behavior (Inappropriate Severe):** Care which suggest a reckless disregard of the practitioner's duty to the patient, through gross negligence, general incompetence or actual intent to provide substandard care. Such cases will be referred immediately to the Chief of Staff and Service Chief notification.

E. Care Rating: System of Care

1. **Care System Improvement Opportunity:** A means to improve the care system to reduce caregiver errors, mitigate the effects of any errors, or otherwise better support the care process. This rating will apply whenever a system improvement opportunity is identified, independent of any individual practitioner's care rating.

F. Professional Behavior

- A high standard of professional behavior, ethics, and integrity is expected of each individual member of the Medical Staff at Stanford Hospital and Clinics (SHC) in order to promote an environment conducive to providing the highest quality of care.
- Refer to the "Medical Staff Code of Professional Behavior" Policy for the approved process.

G. Peer

1. A "peer" is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.
2. The PPEC designated to perform a review will determine the degree of subject matter expertise required for a provider to be considered a peer for all professional practice evaluations performed the Medical Staff.

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**V. PROCESS/PROCEDURE**

A. OPPE review

1. Rule and rate based indicators:
  - a. Each PPEC identifies relevant rule and rate based indicators for its divisions and/or services.
  - b. Predetermined thresholds for each indicator are identified as appropriate.
  - c. When a threshold is exceeded, the PPEC determines whether additional review is required.
  - d. Rule and rate based indicators are evaluated periodically to determine if the indicator(s) and threshold(s) should be modified.
2. Individual case reviews:
  - a. Cases for individual case review will be based on "significant clinical events" identified by:
    - 1) Incident reports
    - 2) Patient / family complaints
    - 3) Sentinel events / adverse events
    - 4) As required by regulatory agencies
    - 5) Referral from clinician(s)
    - 6) Referral from Morbidity and Mortality conferences
    - 7) Referral from Risk Management
  - b. Individual case reviews may also be performed when a threshold for a rule or rate based indicator is exceeded.

B. Indications for focused professional practice evaluation (FPPE)

1. Any single egregious case or sentinel event as judged by the relevant PPEC, the CIC, the Service Chief, the MEC or the Chief of Staff, may be referred to the CIC for consideration of FPPE.
2. When indicator thresholds are exceeded within the agreed upon time.
  - a. The number of cases rated "care inappropriate" or "improvement opportunity" exceeds a threshold defined by the CIC.
  - b. A rate or rule based indicator exceeds a predetermined threshold defined by the appropriate PPEC.

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- c. These indicators do not result in automatic referral to CIC for consideration of FPPE. The relevant PPEC will consider whether referral is indicated based on the individual circumstances.
3. FPPE's are personalized and individualized to the specific physician and the issues present. The CIC, or the specific PPEC delegated by the CIC, identifies a timeframe and individualized plan for the completion of the FPPE process, monitors the physician's compliance with the process, and communicates directly with the physician regarding the expectations and timeline.
4. Upon referral, the CIC will determine whether FPPE is warranted.

C. OPPE Review Process

1. OPPE is conducted continuously and reported to the appropriate PPEC for review and action.
2. Each case for review will be assigned to an appropriate PPEC member for presentation to the committee.
3. The attending physicians identified in a case for full review will be notified in advance and invited to attend the PPEC meeting and/or submit a written summary of the case.
4. The reviewer will report the reason for the referral and review the medical record. The reviewer may recommend that further information be obtained before further committee review.
5. The reviewer will present the case to the committee and, if applicable, the attending physician(s) involved in the case may provide additional information before being excused.
6. If the attending physician did not attend the meeting and further information is needed, the attending physician will be asked to respond in writing, or in person, at the next PPEC meeting.
7. PPEC Committee rates each case.
8. The attending physician(s) or other licensed independent practitioner is notified in writing of the outcome.
9. If a practitioner disagrees with any finding of the PPEC, he or she may submit written comments that will be filed with the committee's findings.
10. If corrective action is recommended by the PPEC and the practitioner disagrees, the case will be referred to CIC. In such a case, one member of the CIC will be asked to review the case from

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the practitioner's perspective. This member may be selected by the practitioner if the practitioner so desires.

11. If one PPEC disagrees with the decision of another PPEC on an issue which is of concern to both bodies, that issue may be referred to CIC.
12. All recommended coaching, education, or other corrective measures will be conveyed to the practitioner by the Service Chief and/or Deputy Chief and will be tracked by the Service Quality Manager with results reported to the PPEC.
13. Any corrective measures recommended and accepted at the PPEC level will be reported to the CIC before and after completion of those measures.
14. Care provided by resident physicians will be attributed to the attending/supervising physician during the evaluation and rating process. However, concerns about house officer performance issues will be referred to the Graduate Medical Education (GME) office, as will any process issues relating to house officer supervision. The GME office will be asked to provide feedback to the CIC as to the results of any such referrals.
15. Decisions of PPEC will be determined by simple majority vote.

D. FPPE Review Process

1. The FPPE process will be essentially parallel to the OPPE process, with the following exceptions:
  - a. Any FPPE (with the exception of routine proctoring) will be overseen by the CIC.
  - b. Review is not restricted to individual cases, rates and rules, but may extend to all areas of practice, as determined by the CIC.
  - c. All recommended coaching, education, or other corrective measures will be conveyed to the practitioner by the CIC Chair, the Chief of Staff or the Service Chief, and will be tracked by the Services Quality Manager with results reported to the relevant PPEC and the CIC.
  - d. The MEC will receive regular summaries of such focused reviews, including major findings, conclusions, recommendations and required actions, at least annually.

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E. Reliability and Consistency of the Review Process

1. Professional practice evaluation will be conducted in a manner that is objective, equitable, and consistent.
  - a. Case selection will be done by use of pre-selected indicators and also through criteria outlined in the quality plans for each service or division.
  - b. Review of cases will be performed by PPECs in accordance with procedures outlined in this document.
  - c. If a PPEC believes another PPEC has erred in its judgment on a given case, it may refer that case to CIC.
2. The CIC will monitor reliability and consistency of each PPEC based on quarterly activity reports submitted to CIC, and will in turn report its findings to the MEC.

F. Participants in the Review Process

1. PPEC members will normally be chosen by the Service Chief(s), subject to review and approval by the CIC and MEC. CIC membership is described in the Bylaws. Every PPEC must include at least three active Medical Staff members in good standing.
2. Divisions which have a substantial population of patients who have community attending physicians should have at least one community attending physician, normally the Deputy Chief (or designee), as a committee member.
3. The Service Chief(s) will consider rotation of members at least once every three years.
4. The PPEC chairs shall be appointed by the Service Chief(s) with the approval of the CIC and MEC. The term of appointment is three years. A chair may be reappointed by the service chief for up to two terms (six years) in total. Extending beyond 6 years requires prior MEC approval.
5. A liaison from the Quality Improvement Patient Safety Department (QIPSD) will be assigned to support each PPEC and will attend all meetings, assist with facilitating the committee's work and report, along with the committee chair, to the CIC. This individual also prepares data and coordinates follow up monitoring.
6. Service chiefs are encouraged to appoint resident physicians as non-voting members of PPECs

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7. Support staff will participate in the review process as deemed appropriate based on their job responsibilities.

G. Professional practice evaluation (PPE) time frames

1. The PPE will be conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed as quickly as possible and within 120 days from the date of referral.
2. Complex cases may require additional review time beyond 120 days. The status of complex cases will be monitored by the Quality Improvement and Patient Safety Department and the practitioners involved will be kept apprised of the process. A complex case may be one where multiple services are involved, or one which requires external review for reasons identified in section V.J.
3. An FPPE may also take longer to complete, but the involved practitioner should be kept well informed as to the proceedings.

H. Oversight and reporting

1. Direct oversight of the professional practice evaluation process is delegated by the MEC to the CIC.
2. The CIC will meet regularly to review the findings of the PPECs.
3. The CIC will report to the MEC at least quarterly.
4. The Chief of Staff and the Committee on Professionalism, who are jointly responsible for addressing issues of professional behavior (see Medical Staff Code of Professional Behavior), will report on those issues at least annually to the CIC and the MEC.

I. Circumstances Requiring External Professional Practice Evaluation

1. External professional practice evaluation may take place under the following circumstances when deemed appropriate by the CIC, the MEC, or the Chief of Staff.
  - a. Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees, when conclusions from this review will directly affect a practitioner's privileges.

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- b. Lack of internal expertise – when no one on the Medical Staff has adequate expertise in the specialty or specific issues under review or when the only practitioners on the Medical Staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above.
  - c. Other – when the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the CIC, MEC or Chief of Staff may obtain external professional practice evaluation in any circumstances deemed appropriate.
2. The Chief of Staff will inform the MEC when there is a request for external professional practice evaluation. Input from the relevant Service and/or Division Chief, as well as the practitioner being reviewed, should be solicited and considered prior to engaging external evaluation, when appropriate.

J. Conflict of Interest

1. A member of the Medical Staff asked to perform professional practice evaluation has a conflict of interest if, for example, he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the physician involved as direct competitor or partner.
2. It is the individual reviewer's obligation to disclose any potential conflict to the PPEC.
3. Procedures for addressing potential conflicts of interest are outlined in the Conflict of Interest for Medical Staff Policy.

VI. CONFIDENTIALITY

1. Professional practice evaluation information is privileged and confidential in accordance with Medical Staff and hospital bylaws, state and federal laws (including California Evidence Code 1157), and regulations pertaining to confidentiality and non-discoverability.
  - a. PPEC members will sign a statement of confidentiality and will be subject to disciplinary action for violations of confidentiality, as outlined in the Medical Staff Bylaws.

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- b. The hospital will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in secure locations approved and controlled by the MEC and Chief of Staff. Provider specific professional practice evaluation information includes information related to:
  - 1) Performance data for all dimensions of performance measured for that individual physician.
  - 2) The individual physician's role in sentinel events, significant incidents, or near misses.
  - 3) Correspondence to the physician regarding recommendations, comments regarding practice performance, or corrective action.
  - 4) Reports and correspondence regarding alleged disruptive behavior.
- c. Professional practice evaluation information is available only to authorized individuals who have a legitimate need for this information based upon their quality improvement responsibilities as a Medical Staff leader or hospital employee. Individuals shall have access to the information only to the extent necessary to carry out their assigned responsibilities. All individuals with allowed access to such information will sign a statement of confidentiality. Any questions regarding authorization shall be resolved by the Chief of Staff and/or MEC.
- d. On request, any practitioner may review his or her own quality data. Reports filed by another individual (incident reports) will be redacted to protect that person's identity. Practitioners may provide a written response to anything in their quality file, and this response will be kept with the other quality information.
- e. No copies of professional practice evaluation documents will be created and distributed except as authorized by this policy, which includes giving authority to do so to the Chief of Staff, or in unusual circumstances, certain designees of the Chief of Staff.

**VII. RELATED DOCUMENTS**

- A. Medical Staff Bylaws and Rules and Regulations of the Medical Staff

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- B. Administrative Policy Manual
- C. Joint Commission Accreditation Standards: Medical Staff

### VIII. DOCUMENT INFORMATION

- A. Legal Authority/References
  - 1. Hospital Accreditation Standards
  - 2. California Evidence Code 1157
- B. Author/Original Date  
December 11, 2006
- C. Distribution and Training Requirements
  - 1. This policy resides in the Medical Staff Office Policy Manual for SHC.
  - 2. New documents or any revised documents will be distributed to physicians through the Medical Staff Office.
- D. Review and Renewal Requirements  
This policy will be reviewed and/or revised every three years or as required by change of law or practice.
- E. Review and Revision History
  - 1. Medical Staff Quality Assurance and Improvement Activities  
October 2002
  - 2. Medical Staff professional practice evaluation Policy December 2006
- F. Approvals
  - 1. Care Improvement Committee - April 2010
  - 2. SHC Medical Executive Committee - June 2010
  - 3. SHC Board of Directors - June 2010

Reference and Credit: The original PPEC policy dated 2006 was done in collaboration with Lucille Packard Children's Hospital and was based on the Sample Medical Staff Peer Review Policy location in *Effective Peer Review: A Practical Design to Contemporary Design* was done with written consent.<sup>1</sup>

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<sup>1</sup> *Effective Peer Review: A Practical Design to Contemporary Design*, Second Edition, HCPro, Massachusetts

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