

Standards BoosterPak™ for Focused Professional Practice Evaluation/ Ongoing Professional Practice Evaluation (FPPE/OPPE)



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A. Description of Standard and Implementation Expectations

Section A1: Standard Rationale, Elements of Performance (EPs), Scoring Categories, Implementation Suggestions

Focused Professional Practice Evaluation (FPPE)

Program: Hospital and Critical Access Hospital

Chapter: Medical Staff

Standard number: MS.08.01.01

Standard Text: The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.

Rationale: The focused evaluation process is defined by the organized medical staff. The time period of the evaluation can be extended, and/or a different type of evaluation process assigned. Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).

Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with the organization's policies and procedures that are intended to preserve confidentiality and privilege of information.

Element of Performance:

1. A period of focused professional practice evaluation is implemented for all initially requested privileges.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- This includes practitioners new to the organization and practitioners already on staff requesting new privileges.
- The "period" of focused professional practice evaluation can be either of the following:
 - o Time (volume may be excessive or insufficient)
 - o Procedure/admission/activity oriented (allows for flexibility and dealing with infrequently performed privileges)
- Review type can vary:
 - o Direct observation
 - o Chart review
 - o Simulation
 - o Discussion with other individuals involved in the care of each patient, including consulting practitioners, surgical assistants, nurses, and administrative personnel

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- The duration of FPPE may be tiered for different levels of documented training and experience:
 - o Practitioners coming directly from an outside residency program (unknown data)
 - o Practitioners coming directly from the organization's residency program (have data)
 - o Practitioners coming with a documented record of performance of the privilege and its associated outcomes versus those with no record
- Although the process may vary based on different levels of documented training and experience, no one can be excused from the process of initial evaluation.

Tips:

- Taking a course does not prove competency.
- Allow no exemption for board certification, documented experience, or reputation.
- If using time frames, you may need to extend if minimum activity does not occur.
- Group very similar activities together:
 - o Evaluate a set number of any mix of the privileges; for example, any ten from the group will be evaluated to determine competence for the whole group.
 - o Cannot just look at one privilege from the group.
- The six general competencies may be used as a framework:
 1. Patient care
 2. Medical/clinical knowledge
 3. Practice-based learning and improvement
 4. Interpersonal and communication skills
 5. Professionalism
 6. Systems-based practice

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Element of Performance:

2. The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Develop criteria based on specialty and/or specific procedure.
- Should be objective and not just based on another practitioner's personal knowledge.
- Evaluation of OPPE data (MS.08.01.03) indicates that focused evaluation may be in order.

Tip:

- The six general competencies may be used as a framework.

Element of Performance:

3. The performance monitoring process is clearly defined and includes each of the following elements:
- Criteria for conducting performance monitoring
 - Method for establishing a monitoring plan specific to the requested privilege
 - Method for determining the duration of performance monitoring
 - Circumstances under which monitoring by an external source is required

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Some criteria may be applicable to all (for example, pharmacy intervention for medication orders, ability to locate physician when on call).
- Other criteria should be measures that are specialty-specific and evidence-based (for example, return to surgery, post-op infection rate).
- Duration of monitoring can be based in a specific time frame or on a number of cases, as appropriate.
- Monitoring plan should be based on the type of privilege in question:
 - o Robotic surgery versus management of diabetic patient
 - o The plan must allow for the realistic evaluation of the practitioner—will chart review provide the full picture allowing for a comprehensive and fair outcome?

Tips:

- Develop a checklist/form of the required steps.
- Various specialty boards have specialty-specific defined criteria for performance monitoring.
- The six general competencies can be used as a framework.

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Element of Performance:

4. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- All practitioners are treated equitably.
- Criteria are applied as defined by the medical staff.
- Specialty-specific data/indicators for the same privilege are managed the same way for all practitioners with that privilege.

Element of Performance:

5. The triggers that indicate the need for performance monitoring are clearly defined.

Note: Triggers can be single incidents or evidence of a clinical practice trend.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Triggers are defined as unacceptable levels of performance within the established defined criteria.
- Some triggers to consider:
 - o Defined number of events occurring
 - o Defined number of individual peer reviews with adverse determinations
 - o Elevated infection rates
 - o Sentinel events
 - o Small number of admissions/procedures over an extended period of time
 - o Increasing lengths of stay compared to others
 - o Increasing number of returns to surgery
 - o Frequent/repeat readmission for the same issue
 - o Patterns of unnecessary diagnostic testing/treatments
 - o Failure to follow approved clinical practice guidelines

Tip:

- Triggers need to be sensitive enough to ensure that all practitioners are practicing the highest quality of care:
 - o If OPPE is not identifying any practitioner performance issues through its process, then the indicators may not be as sensitive as they should be.
 - o A balance between false negative and false positive indicators is important.

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Element of Performance:

6. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.

Note: Other existing privileges in good standing should not be affected by this decision.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Evaluation of OPPE on an ongoing basis should help identify potential problems early to allow for correction/improvement.
- Affects only the privilege in question.
- Department chair (or whoever is evaluating the data) makes the determination to assign a period of focused evaluation.

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Element of Performance:

7. Criteria are developed that determine the type of monitoring to be conducted.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Criteria for type of monitoring is based on the triggering issue/specialty-specific data indicators:
 - o Chart review (by internal or external reviewer)
 - o Direct observation
 - o Simulation
 - o Discussion with other individuals involved in the care of each patient
 - o Defined length of time or number of cases
 - o Individual and/or committee review
 - o Review may be extended depending on findings.
- Objectivity is key—may need to utilize external reviewers in some circumstances:
 - o When the procedure is new to the organization
 - o When the reviewers are economic competitors of the practitioner
 - o When the process needs to be fair, balanced, and educational

Element of Performance:

8. The measures employed to resolve performance issues are clearly defined.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestion:

- Performance improvement plan can include the following:
 - o Necessary education
 - o Proctoring/assisting for defined privilege
 - o Counseling
 - o Physician/practitioner assistance programs
 - o Suspension of specific privileges
 - o Revocation of specific privileges

Tips:

- Improvement plan must be documented and include the requirements, who is accountable, and how the improvement will be measured and documented.
- Prospective and real-time evaluation is important to ensure safe, competent care.

Element of Performance:

9. The measures employed to resolve performance issues are consistently implemented.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestion:

- Method of improving performance for a specific privilege needs to be consistently applied to any practitioner undergoing FPPE for that privilege.

Tip:

- The outcome of FPPE needs to be documented and decisions made as to the following:
 - o Further need for FPPE
 - o Continuation or limiting of the privilege

Ongoing Professional Practice Evaluation (OPPE)

Program: Hospital and Critical Access Hospital

Chapter: Medical Staff

Standard number: MS.08.01.03

Standard Text: Ongoing professional practice evaluation 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 renewal.

Rationale: None

Element of Performance:

1. The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.

Scoring Categories:

Criticality level: Indirect

Documentation required: Yes

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Data are collected for every practitioner:
 - Not just for those with performance issues
 - Information is used to identify performance issues early so intervention can occur early.
- Use data you already collect to track compliance when possible:
 - Surgical Care Improvement Project (SCIP)
 - Core measures
 - Medical record delinquency
 - Medical staff performance improvement data as required at MS.05.01.01
 - Return to surgery data
 - Infection control surveillance data
 - Procedural complication data
 - Other types of data
- Define how the data are collected
- Define who reviews the data:
 - Department chair
 - Credentials committee
 - Medical Executive Committee (MEC)
 - Special committee
- Define frequency of data evaluation:
 - Must be more frequent than annually.
 - Many organizations evaluate every 6–8 months so there are three data points at time of reprivileging.
- Define how the data will be evaluated:
 - What is acceptable
 - What is not acceptable
 - What needs further monitoring
 - When FPPE needs to be considered/implemented

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Tips:

- Determine what data are already being collected for quality/billing purposes.
- Determining data collection for A.P.R.N.s and P.A.s may require more effort as they tend to not be tracked by traditional coding practices.
- The six general competencies may be used as a framework.

Element of Performance:

2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

- Consider selecting two or three general measures that apply to all medical staff, which could include the following:
 - o Medical record delinquency
 - o Dating and timing entries in the medical record
 - o Do-not-use abbreviations
 - o Pharmacy interventions for medication orders
 - o History and physical (H&P)—timeliness, legibility, completeness
 - o Length of stay
 - o Appropriate use of consultants
 - o Complaints and compliments
 - o Professional behavior
 - o Routine pages returned within defined time frame
- Clinical departments determine data to be collected—should be specialty-specific and could include the following:
 - o Data already being collected for other quality initiatives (*see* EP 1)
 - o Blood utilization
 - o Morbidity and mortality
 - o Number and types of procedures performed
 - o Need for reversal agent after moderate sedation
 - o Core measures
 - o National Surgical Quality Improvement Program
 - o Specialty related examples such as the following:
 - Anesthesia:
 - Reintubation
 - Dental injury
 - Spinal headache
 - Gynecology:
 - Documented conservative treatment before hysterectomy
 - Ureteral or visceral damage during surgery
 - More than four day stay after hysterectomy
- Data should not be limited to negative/outlier/trending data.
- Good performance data need to be considered as well.
- Zero data *is* data:
 - o May indicate positive—no infections is good.
 - o May indicate negative—has not performed the privilege in a long time.

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Tips:

- Try to use indicators for which data are easy to obtain (may change over time).
- Set thresholds for further review, such as three instances in three months.
- Document “zero” data (which *is* data) as well:
 - o Can be evidence of good performance:
 - No returns to the OR
 - No complications
 - No complaints
 - No infections
 - o Important to know when a practitioner is not performing certain privileges over time:
 - Should be evaluated as to the following:
 - Why the practitioner is no longer performing the procedure
 - Is the practitioner taking patients needing the procedure to another organization?
 - Whether the procedure is typically low volume and has yet to be done

Element of Performance:

3. The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestion:

- Define the process for utilizing the information from OPPE in the credentialing process:
 - o Will the privilege continue, need to be limited, or revoked:
 - Continue the privilege unchanged.
 - Direct further education.
 - Direct FPPE.
 - Modify an existing privilege.
 - o Who makes the determination
 - o How the evaluation outcome will be documented in the credentials file, when, and by whom
 - o Where the data will be stored

Tips:

- Many organizations keep the data separate from the credentials file.
- Only the outcome of the evaluation needs to be documented in the credentials file.
- May consider sharing data with the practitioners themselves:
 - o They can see areas in which they are doing well.
 - o They may seek to self-modify behavior.
 - o Presentation of comparative data aggregated from peers can be a strong influence:
 - Scorecards
 - Report cards
 - Dashboard

Section A2: Assessing Compliance During the On-Site Survey

[Content adapted from the *2010 Hospital Survey Activity Guide*—Medical Staff Credentialing and Privileging Session]

Objective: The Medical Staff Credentialing and Privileging Session will be used to do the following:

- Explore how the organization monitors the performance of practitioners on a continuous basis, identifies substandard performance, and implements interventions to address identified safety and quality-of-care issues

Surveyors will ask to discuss your credentialing/privileging process, along with the following:

- The scope of the medical staff process to determine if all licensed independent practitioners and other practitioners are reviewed (*see* Section B3)
- Consistent implementation of the process for all practitioners
- The link between results of peer review and focused monitoring and the adherence to peer review and focused monitoring criteria
- How your organization is monitoring the performance of all licensed independent practitioners on an ongoing basis (ongoing professional practice evaluation)
- How your organization is evaluating the performance of licensed independent practitioners who do not have current performance documentation at the organization (focused professional performance evaluation)
- How your organization is evaluating licensed independent practitioners whose performance has raised concerns regarding the provision of safe, high-quality care (focused professional performance evaluation)
- The mechanism to communicate practitioner privileges and ensure that practitioners practice within the scope of their defined privileges

Documents for Review:

- Required: Credential files
- Required: Medical staff bylaws, rules and regulations, and MEC minutes

Suggestions:

- Close association between quality department and medical staff office can improve access to data.
- Having data in usable, concise format is important to get buy-in from medical staff who in many organizations are essentially “volunteering” their time to review and evaluate the data.

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[Content adapted from the *2010 Hospital Survey Activity Guide*—Medical Staff Credentialing and Privileging Session]

Objective:

- The surveyor will evaluate the credentialing and privileging process for the medical staff and other licensed independent practitioners who are privileged through the medical staff process.

Overview

- During this session, the surveyor discusses the following with organization participation:
 - o Consistent implementation of the credentialing and privileging process for the medical staff and other licensed independent practitioners who are privileged through the medical staff process
 - o Whether practitioners practice within the limited scope of delineated privileges
 - o The link between peer review and focused monitoring to the credentialing and privileging process
 - o Potential concerns in the credentialing, privileging, and appointment process

B. Frequently Asked Questions, Definitions, and Additional Information About Specific Topics

Section B1: Frequently Asked Questions (FAQs)

(As of November 7, 2010, on the Joint Commission Web site)

Revised October 13, 2008

Focused Professional Practice Evaluation

Q: What is the intent of the Focused Professional Practice Evaluation requirement?

A. There are essentially two components:

1. Element of Performance 1, which requires “A period of focused professional practice evaluation is implemented for all initially requested privileges.” This would mean all privileges for new practitioners and all new privileges for existing practitioners. The EP was published in January 2007 with an effective date of January 1, 2008.
 2. Elements of Performance 2–9, which were relocated from the 2006 standard MS.4.90. These elements address what had previously been termed “Peer Review.”
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Revised October 13, 2008

Focused Professional Practice Evaluation for New Privileges

Q: What is the requirement for new privileges?

A: A period of focused review is required for all new privileges, meaning all privileges for new applicants and all new privileges for existing practitioners. There will be no exemption for board certification, documented experience, or reputation. All applicants for new privileges must have a period of focused review.

Q: Must the process be predefined or can it be determined for each specific applicant for the new privilege?

A: The components for design are listed in EP 3 and would include, but not be limited to, the following:

- Criteria for conducting performance evaluations
- Method for establishing the monitoring plan specific to the requested privilege
- Method to determining the duration of performance monitoring
- Circumstances under which monitoring by an external source is required

The organization may choose to use the methodologies for collecting information, such as those outlined at MS.08.01.03 for ongoing professional practice evaluation:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nurses, and administrative personnel

There is nothing in EP 3 that would prevent the design of a multitiered/multilevel approach. The type of review can certainly be different, particularly for different privileges (for example, for some, direct observation is appropriate, but for others, chart audits are more appropriate).

Q: Must the process be defined in writing or defined in the medical staff bylaws?

A: The process would need to be predefined as EP 4 requires that focused professional practice evaluation be consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. Because the process must be consistently implemented (EP 4), the organization may wish to put it in writing. There is no requirement that it be in the medical staff bylaws.

Q: What is the duration of the monitoring—for example, can it be a 12-month provisional period?

A: With regard to establishing the monitoring plan specific to the requested privilege, and the possibility of using a 12-month provisional period, it is important to remember that there is no required provisional period. The provisional period, when it was required, related to appointment to the medical staff and not to privileges. Using a 12-month provisional period for focused review might be burdensome when the volume of activity is very large.

It may be more appropriate to consider a different approach for high-volume versus low-volume privileges or high-risk versus low-risk privileges (for example, performing a focused review for a defined number of admissions, such as the first 5, 10, 20, and so forth; or a defined number of procedures, such as 5, 10, 20, and so forth; or for a short period of time, such as one month or three months). For an infrequently performed privilege, numbers might work better than a time period, particularly if the privilege is not performed in that time period.

Although the EP would require an evaluation of each new privilege, it could be possible to group very similar activities together and then evaluate a set number of any mix of the privileges (for example, any 10 from the group will be evaluated to determine competence for the whole group, but you cannot just look at only 1 privilege from the group).

The duration could also be different for different levels of documented training and experience, such as the following:

- Practitioners coming directly from an outside residency program
- Practitioners coming directly from the organization's residency program
- Practitioners coming with a documented record of performance of the privilege and its associated outcomes
- Practitioners coming with no record of performance of the privilege and its associated outcomes

Q: Can the focused review for new privileges be only for performance issues or when triggers occur?

A: A focused review/peer review process for new privileges, which is triggered by practice indicators that relate only to untoward outcomes, would not meet the intent of EP 1 as a focused practice review for all privileges for new applicants and new privileges for existing practitioners is required.

The bottom line principles are as follows:

- The process must be defined.
- The process must be consistently implemented as defined.
- All new privileges (new applicants and new privileges for existing practitioners) must be reviewed in accordance with the defined process.

Revised October 13, 2008

Focused Professional Practice Evaluation for Performance Issues

Q: What is the distinction between performance issues and triggers and are there any examples?

A: The standard requires that the organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high-quality patient care are identified (EP 2).

In addition, the triggers that indicate the need for performance monitoring are clearly defined (EP 5). Triggers can be single incidents or evidence of a clinical practice trend.

There is a somewhat fine line between criteria and triggers but triggers are the very obvious issues (for example, infection rates, sentinel events, complaints, other events that are not sentinel events).

Criteria for performance issues might include, but not be limited to the following:

- Small number of admissions or procedures over an extended period of time that raise the concern of continued competence
- A growing number of longer lengths of stay than other practitioners
- Returns to surgery
- Frequent or repeat readmission suggesting possibly poor or inadequate initial management/treatment
- Patterns of unnecessary diagnostic testing/treatments
- Failure to follow approved clinical practice guidelines—may or may not indicate care problems, but why the variance?

Issues affecting the provision of safe, high-quality patient care and that indicate the need for performance monitoring may be identified as part of the ongoing practitioner performance evaluation in MS.08.01.03.

There may also be negative or outlier data on a practitioner that will be used to identify the triggers that indicate the need for performance monitoring.

Q: Are there any required components for design of the focused evaluation process?

A: The four required components for design of the process are outlined in EP 3:

1. Criteria for conducting performance evaluations
2. Method for establishing the monitoring plan specific to the requested privilege
3. Method for determining the duration of performance monitoring
4. Circumstances under which monitoring by an external source is required

Because the process must be consistently implemented (EP 9), the organization may wish to put it in writing. There is no standard requiring that it be in the medical staff bylaws.

With regard to establishing the monitoring plan specific to the requested privilege it could either be predefined for different types of performance issues or triggers, or it could be appropriate to allow the

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reviewers to recommend to the organized medical staff the type of monitoring and duration based on the issue under review.

Q: Are there any guidelines for how to collect information for evaluation?

A: The organization may choose to use the methodologies for collecting information outlined in MS.08.01.03 for ongoing professional practice evaluation:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nurses, and administrative personnel.

Q: Is this really just the process that was historically called “peer review”?

A: The Joint Commission renamed “peer review” to be termed “focused review of practitioner performance” in 2004. The current term is now “focused professional practice evaluation.” If an organization’s current “peer review” process includes the criteria to be used for identified performance issue (EP 2), defined triggers that indicate the need for performance monitoring (EP 5), the four required components outlined in EP 3, and the remaining requirements at EPs 4 and 6–9, it would meet the intent for the existing focused professional practitioner evaluation covered by EPs 2–9.

Updated March 15, 2010

Ongoing Professional Practice Evaluation (OPPE)

Q: What is the intent of the requirement for ongoing professional practice evaluation?

A: 1. The intent of the standard is that organizations are looking at data on performance for all practitioners with privileges on an ongoing basis, rather than at the two-year reappointment process, to allow them to take steps to improve performance on a more timely basis.

2. A clearly defined process would include but not be limited to the following:

- Who will be responsible for reviewing performance data? For example, in smaller organizations the department chair or the department as a whole at their department meetings might be able to review all department members. In larger organizations it could be the responsibility of the credentials committee, the MEC, or a special committee of the organized medical staff.
- How often the data will be reviewed. The frequency of such evaluation can be defined by the organized medical staff (for example, 3 months, 6 months, 9 months, and so forth). However, as noted in the teleconferences during 2007, 12 months would be periodic rather than ongoing.
- The process to be implemented to use the data to make decision as to whether to continue, limit, or revoke privileges. This could include defining who can make and approve a recommendation for action (for example, the department chair when no action is required, the MEC and governing body for limitation or revocations).
- How data will be incorporated into the credentials files. There needs to be a defined process for the data to be in the record and for the review to occur. This can include storing the data out of the

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record and making them available with the record at the time of the review. There is no requirement that the data be continuously stored in the credentials file.

The decision resulting from the review, whether it be to take an action or to continue the privilege, would need to be documented along with the supporting data.

3. The types of data to be collected would need to be defined by individual medical staff departments and approved by the organized medical staff. The standards require an evaluation for all practitioners, not just those with performance issues. The departments will know best what types of data will reflect both good and problem performance for the various practitioners in their departments. The organized medical staff will then determine if the correct types and amount of data are being collected.

The standard's rationale outlines suggested data that the organization may choose to collect along with the following suggestions for methodologies for collecting information:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nurses, and administrative personnel.

Some types of data apply to all practitioners, but because performance is different for different practitioners (for example, cardiologist versus orthopedists versus obstetricians), there may need to be specific data.

In addition, because most practitioners perform well, there would need to be data on their actual performance as well as those with performance issues. The fact that a practitioner doesn't fall out on predefined screening criteria is not sufficient to meet the requirement for performance data on every practitioner.

It is also important to remember that zero data is in fact data. Zero data can actually be evidence of good performance (for example, no returns to the OR, no complications, no complaints, no infections, and so forth).

It is also important to know when a practitioner is not performing certain privileges over a given period of time. It would not be acceptable to find at the two-year reappointment that a practitioner has not performed a privilege for two years.

4. The information resulting from the evaluation needs to be used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed. Based on analysis, several possible actions could occur, including but not limited to the following:

- Determining that the practitioner is performing well or within desired expectations and that no further action is warranted
- Determining that issues exist that require a focused evaluation
- Revoking the privilege because it is no longer required
- Suspending the privilege, which suspends the data collection, and notifying the practitioner that if he or she wishes to reactivate it, the practitioner must request a reactivation

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- Determining that the zero performance should trigger a focused review (MS.4.30, EP 5) whenever the practitioner actually performs the privilege
- Determining that the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients

Evidence of these determinations would need to be included in each practitioner's credentials files at the time of each review of the data.

Updated March 15, 2010

Ongoing Professional Practice Evaluation for Medical and Cognitive Specialties

Q: Meaningful data that can be evaluated are very tough to identify in *medical and cognitive specialties* (internal medicine [IM], family practice [FP], psychiatry, and so forth). Is there any guidance that The Joint Commission can offer to assist organized medical staffs?

A: In some medical and cognitive specialties, it can be difficult to identify meaningful data that can be evaluated. Due to the confidential nature of psychiatry, for example, it is often not possible to observe the provision of care, treatment, and services by the practitioner.

It is important to start with the types of privileges that are granted. In addition to managing medical conditions, practitioners in these specialties often perform procedures.

The Joint Commission Resources publication *Credentialing, Privileging, Competency, and Peer Review: Examples of Compliance for the Medical Staff* has some excellent detailed privilege forms for a wide variety of specialties, including, but not limited to, IM, FP, OB/GYN, cardiac, cardiovascular disease, clinical psychology, dentistry, emergency medicine, gastroenterology, and medical imaging. (Also, explore the Joint Commission's Leading Practice Library [see page 32] for additional examples from some of our selected organizations.)

As you look at the way the privileges are detailed you can begin to identify data to collect, including, but not limited to, numbers of activities, length of stay, complications, management of complications, reasons for readmissions, use of diagnostics, medications or other modalities, and so forth.

Other data to be considered would include, but not be limited to the following:

- Compliance with the Joint Commission core measures (for the applicable practitioners)
- Compliance with organization specific clinical practice guidelines
- Medication prescribing practices (for example, number of times a drug is prescribed, appropriateness to diagnosis, appropriateness of dosing, appropriateness of medication monitoring practices)
- Use of diagnostic (for example, appropriateness, overuse/underuse, appropriateness of therapeutic interventions in response to diagnostic testing result)
- Patient readmissions, either inpatient or outpatient, for the same diagnosis/problem, which may indicate inadequate or inappropriate initial treatment
- Patient complaints

Section B2: Definition of Key Terms

(Source: 2011 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook glossary)

Confidentiality: Protection of data or information from being made available or disclosed to any unauthorized person(s) or process(es).

Focused professional practice evaluation: The time limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care.

Licensed independent practitioner: An individual permitted by law and by the organization to provide care, treatment, and services without direct supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.

Medical staff: The group of all licensed independent practitioners and other practitioners privileged through the organized medical staff process that is subject to the medical staff bylaws. This group may include others, such as retired practitioners who no longer practice in the organization but who wish to continue their membership in the group, courtesy staff, scientific staff, etc.

Medical staff bylaws: A document or group of documents adopted by the voting members of the organized medical staff and approved by the governing body that defines the rights, responsibilities, and accountabilities of the medical staff and various officers, persons, and groups within the structure of the organized medical staff; the self-governance functions of the organized medical staff; and the working relationship with and accountability to the governing body of the organized medical staff.

Medical staff, organized : A self-governing entity accountable to the governing body that operates under a set of bylaws, rules and regulations, and policies developed and adopted by the voting members of the organized medical staff and approved by the governing body. The organized medical staff is comprised of doctors of medicine and osteopathy, and, in accordance with the medical staff bylaws, may include other practitioners.

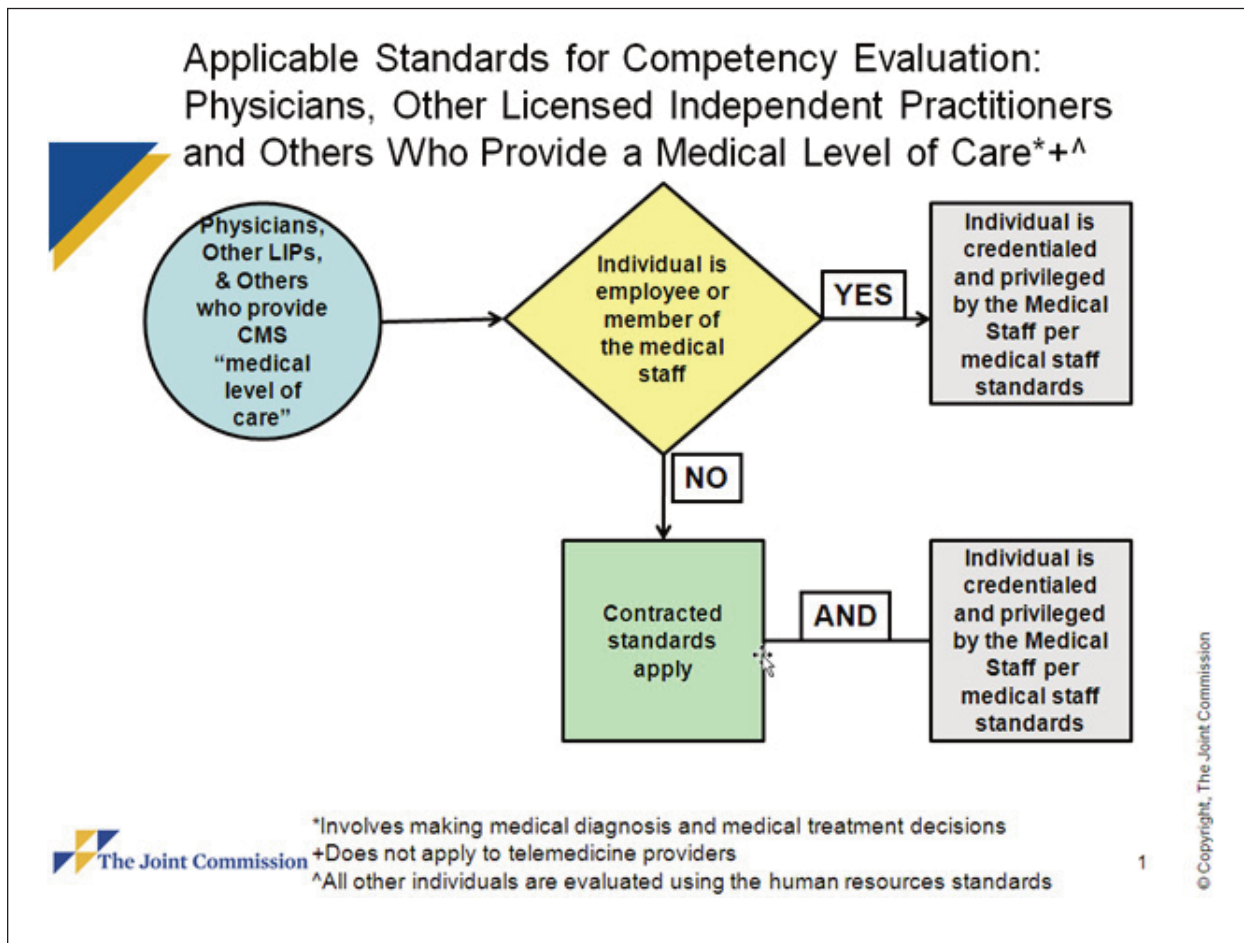
Ongoing professional practice evaluation: A document summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle.

Operative or other high-risk procedures: Includes operative and other invasive and noninvasive procedures (performed in order to remedy an injury, ailment, defect, or dysfunction) that place the patient at risk. The focus is on procedures and is not meant to include medications that place the patient at risk.

Practitioner: Any individual who is licensed and qualified to practice a health care profession (for example, physician, nurse, social worker, clinical psychologist, psychiatrist, or respiratory therapist) and is engaged in the provision of care, treatment, or services.

Privileging: The process whereby the specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance. *See also* licensed independent practitioner.

Section B3: Additional Information About Specific Topics



Those who provide “medical level of care” must use the medical staff process for credentialing and privileging, making all MS standards applicable (including recommendation by the organized medical staff and approval by the governing body, OPPE, and FPPE).

- A.P.R.N.s should request privileges only for those responsibilities involving medical level of care and not those responsibilities already allowed under the R.N. scope of practice.
- A.P.R.N.s and P.A.s who provide “medical level of care” must be credentialed and privileged through the Medical Staff standards process.
- A.P.R.N.s and P.A.s who do not provide “medical level of care” can utilize the human resources “equivalent” process detailed in HR.01.02.05, EPs 10–15.

**C: Supporting Documentation, Evidence, Value, Historical Information,
and Additional References and Links**
Section C1: Supporting Documentation and Evidence

Links to Centers for Medicare & Medicaid Services (CMS) Conditions of Participation:

MS.08.01.03, EP 1, links to §482.22 (a)(1), §482.51 (a)(4), and §482.55 (a)(3)

MS.08.01.03, EP 2, links to §482.22 (a)(1), §482.51 (a)(4), and §482.55 (a)(3)

MS.08.01.03, EP 3, links to §482.22 (a)(1), and §482.55 (a)(3)

§482.22(a)(1) TAG: A-340

(1) The medical staff must periodically conduct appraisals of its members.

§482.51(a)(4) TAG: A-945

(4) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.

§482.55(a)(3) TAG: A-1104

[If emergency services are provided at the hospital —]

(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

Evidence-Base and Consensus Process Used During Development:

Darves B: Ensuring—And Tracking—Physician Competence. NEJM Career Center, Jun. 2008.

<http://www.nejmjobs.org/career-resources/ensure-physician-competence.aspx> (accessed Dec. 1, 2010).

Expert Panel, Task Forces:

Work on Standards MS.08.01.01 and MS.08.01.03 began in 2003 when a 24-member Expert Panel was convened to review the credentialing and privileging standards. The panel was asked to advise The Joint Commission on contemporary credentialing and privileging issues facing health care organizations. There was general consensus among the panel members that the credentialing and privileging processes set forth in the then-current standards were ineffective in facilitating continuous monitoring of performance, identifying substandard performance, and providing a basis for intervening when safety and quality-of-care issues were identified.

As a result, the Expert Panel identified critical new concepts that would support the transition of credentialing and privileging from an intuitive process to one that is more objective and evidence-based. These concepts included focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE).

Standards BoosterPak™ for
Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE)

Field Review Process and Results:

The Joint Commission conducted a field engagement of the revised credentialing and privileging standards, including the new requirements addressing FPPE and OPPE, in October–December 2005. Approximately 560 responses were received; the majority of these were from Joint Commission–accredited hospitals.

The majority of respondents indicated that they were in agreement with the performance monitoring concept presented in Standard MS.08.01.01 (76%). A majority also agreed that the concepts presented in Standard MS.08.01.03 were clear (80%).

The credentialing and privileging standards, along with the results of the field engagement, were subsequently presented to the Hospital Professional and Technical Advisory Committee and to the Public Advisory Group for review and discussion. The revised standards were then reviewed and approved by the Standards and Survey Procedures Committee in April 2006.

FPPE and OPPE first appeared in the January 2007 hospital and critical access hospital accreditation program manuals. To address implementation concerns expressed by the field regarding MS.08.01.01 (FPPE), The Joint Commission displayed 2 of the 10 EPs in the January 2007 accreditation manuals with a note indicating that these 10 EPs would go into effect January 2008. This provided organizations with a year to determine what they would need to do to come into compliance with the EPs.

Feasibility Testing Results (Setting-Specific): *Not applicable.*

Section C2: Value to Field and Related Initiatives

Value to Field (Projected or Actual Experience):

FPPE and OPPE were designed to support the transition of credentialing and privileging from an intuitive process to one that is more objective and evidence-based. They are also intended to help organizations identify and address performance issues as soon as possible so that quality and safety are not compromised.

Relationship to Performance Measures and Other Initiatives:

None identified at this time.

Section C3: Historical Information and Changes

When MS.08.01.01 was introduced in 2007, EPs 1 and 2 required medical staffs to determine the high-risk procedures that required a professional performance record at the hospital and to develop criteria for evaluating the performance of applicants without a current professional performance record at the hospital. Since that time, EPs 1 and 2 have been consolidated into a single EP that requires hospitals to implement a period of focused professional practice evaluation for all initially requested privileges.

Section C4: Additional References and Links

Are you on board with The Joint Commission's FPPE/OPPE requirements? *Hosp Peer Rev* 34:137–141, Dec. 2009.

Catalano E.W., et al.: College of American Pathologists considerations for the delineation of pathology clinical privileges. *Arch Pathol Lab Med* 133:613–618, Apr. 2009.

Courtemanche J., Milano C.: Where are you with Professional Practice Evaluation? Courtemanche & Associates, Nov.–Dec 2008. <http://67.59.186.13/file.axd?file=2008%2f12%2fPPE.pdf> (accessed Dec. 1, 2010).

Echo Supporting Your OPPE/FPPE Compliance Initiatives. Echosoftware.
Available at www.healthlinesystems.com.

Hawkins R., et al.: A multimethod study of needs for physician assessment: Implications for education and regulation. *J Contin Educ Health Prof* 29:220–234, Fall 2009.

Lehigh Valley Health Network, Allentown PA. Professional Practice Evaluation.
Available at www.medicalstaff.lvh.org.

Myers S.S., et al.: Focusing measures for performance-based privileging of physicians on improvement. *Jt Comm J Qual Patient Saf* 34:724–733, Dec. 2008.

Roach P.B., et al.: Continuous, data-rich appraisal of surgical trainees' operative abilities: A novel approach for measuring performance and providing feedback. *J Surg Educ* 66:255–263, Sep.–Oct. 2009.

Tips for creating your OPPE/FPPE policies. *Hosp Peer Rev* 35:3–6, Jan 2010.

Yale-New Haven Hospital: Medical Staff Policy–Focused Professional Practice Evaluation.
Available at www.ynhh.org/medstaff/PFPPE.

Books and Newsletters

Additional information and case study examples can be found in the following publications from Joint Commission Resources:

- The Joint Commission: *Credentialing and Privileging Your Hospital Medical Staff*, 2nd ed. Oak Brook, IL: Joint Commission Resources, 2010.
<http://www.jcrinc.com/Books-and-E-books/Credentialing-and-Privileging-Your-Hospital-Medical-Staff-Second-Edition/2011/>.

Standards BoosterPak™ for Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE)

The following JCR articles address standards compliance issues related to OPPE/FPPE:

- Maintaining existing privileges—Standard MS.4.40. *The Joint Commission: The Source* 6:6–8, Mar. 2008.
<http://www.ingentaconnect.com/content/jcaho/jcts/2008/00000006/00000003/art00003>.
- Conducting ongoing professional practice evaluations (OPPE): How to improve compliance with MS.08.01.03. *The Joint Commission: The Source* 8:1–11, Apr. 2010.
<http://www.ingentaconnect.com/content/jcaho/jcts/2010/00000008/00000004/art00001>.

JCR offers several educational products and services to fit the needs of any health care organization:
<http://www.jcrinc.com/Education-Products-and-Services/>.

Links

National Association of Medical Staff Services

www.namss.org

Centers for Medicare & Medicaid Services Medicare Learning Network: Advanced Practice Nurses and Physician Assistants Web page

https://www.cms.gov/MLNProducts/70_APNPA.asp

To access the Joint Commission's Leading Practice Library to search for Leading Practices on OPPE/FPPE, click the following link:

<https://leadingpractices.jointcommissionconnect.org/sites/extranet/default.aspx>

This will bring you to the sign-in page for the Leading Practice Library on Joint Commission Connect™ using your extranet log-in ID and password

The screenshot shows the 'Sign In' page for the Leading Practice Library on Joint Commission Connect™. The page has a blue header with the logo. Below the header, the text reads: 'Sign In', 'Leading Practice Library', and 'Please use your Joint Commission Connect extranet login id (e-mail address) and password to access the Leading Practice Library. If you experience any login problems, please send an e-mail to LeadingPracticeSupport@Jointcommission.org'. There are two input fields for 'User name:' and 'Password:'. A 'Sign In' button is located below the fields. At the bottom, there is a checkbox for 'Sign me in automatically' and a note: 'Note: Sign me in automatically will remember your Username and Password on subsequent visits to this site'.

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