UNIVERSITY of VIRGINIA HEALTH SYSTEM

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0279

A. SUBJECT: Professional Practice Evaluations for Members of the Clinical Staff

B. EFFECTIVE DATE: September 1, 2013 (R)

C. POLICY:

In order to improve and promote safe, high quality clinical care and to comply with regulatory requirements, the Medical Center shall evaluate the competence of all Members of the Clinical Staff with clinical privileges ("practitioners") in the Medical Center through Professional Practice Evaluations (as defined in this Policy). All practitioners with clinical privileges in the Medical Center, as a condition to receiving and continuation of those privileges, shall participate in Professional Practice Evaluations, including serving as proctors or evaluators from time to time.

Professional Practice Evaluations are a process of reviewing, evaluating and making recommendations as to the adequacy and quality of professional services, as well as the competency and qualifications for professional staff privileges. All proceedings, minutes, records and reports of the Professional Practice Evaluation process are privileged and confidential to the full extent authorized by Virginia Code § 8.01-581.17 and are also exempted from production under Section 2.2-3705.1(1) of the Virginia Freedom of Information Act.

D. DEFINITIONS:

1. Core Privileges: Patient care, including diagnostic techniques, medical management, and procedures, which a practitioner would be qualified to perform upon completion of an accredited residency program or other training program as approved by the Department Chair. The applicable Medical Center Department Chair or Division Chief is responsible for defining the core privileges for his/her department.

2. Non-Core Privileges: Patient care, including diagnostic techniques, medical management, and procedures, which fall outside the core privileges for a given specialty and for which additional training is required. The applicable Medical Center Department Chair or Division Chief is responsible for defining the non-core privileges for his/her department.

3. Focused Professional Practice Evaluation or Focused Evaluation ("FPPE"): A process whereby the Medical Center evaluates the privilege-specific competence of a practitioner for a requested privilege, or when a question arises regarding the ability of a currently privileged practitioner to provide safe, effective high quality care. Focused professional practice evaluation is a time-limited period during which the Medical Center evaluates and determines the practitioner's

professional performance and may be undertaken in a number of ways, including through Peer Review.

4. Ongoing Professional Practice Evaluation or Ongoing Evaluation ("OPPE"): A process that allows the Medical Center to identify professional practice trends of practitioners with privileges in the Medical Center that impact on quality of care and patient safety on an ongoing basis and focuses on the individual member's performance and competence related to his or her Clinical Staff privileges. The process evaluates the quality, adequacy and competency of an individual practitioner's performance and thus is a central part of the institutions' clinician peer review process.

5. Professional Practice Evaluation ("PPE"): Any one or combination of Focused Professional Practice Evaluation or Ongoing Professional Practice Evaluation. These terms include activities traditionally referred to as 'peer review'.

6. Peer: A practitioner whose interest and expertise, as documented by clinical practice or academic rank and/or post graduate degree(s), is reasonably determined to be equivalent in scope and emphasis to that of another practitioner.

7. Peer Review: The traditional term for the process of reviewing, evaluating and making recommendations as to the adequacy and quality of professional services, as well as the competency and qualifications for professional staff privileges. In this Policy, the term "Professional Practice Evaluation", which incorporates traditional peer review, is adopted because it better reflects the use of data on practice patterns to review and evaluate the competency and qualifications of practitioners.

8. Professional Practice Evaluation Subcommittee ("PPES"): A subcommittee of the Credentials Committee charged with reviewing, evaluating and making recommendations concerning the adequacy and quality of practitioner professional clinical practice and competency and qualifications for clinical privileges. Members of the PPES shall be appointed by the President of the Clinical Staff and the Vice President and Chief Executive Officer of the Medical Center and shall include representatives from the Credentials Committee and the Quality Committee. The chair of PPES shall be appointed by the chair of the Credentials Committee. The PPES shall report to the Credentials Committee.

E. PROCEDURE:

1. Focused Professional Practice Evaluation Process – New Privilege Situation. When a practitioner initially requests a privilege, whether at the time of initial appointment, reappointment, or between reappointment cycles, he or she shall submit documentation of clinical experience and specialized training to support his or her competency and qualifications. When such information is not available or there is not enough evidence to verify the privilege-specific competency of the practitioner within 90 days of the initial grant of privileges, a Focused Evaluation will be utilized.

    a. For practitioners seeking initial privileges at the Medical Center, the Focused Evaluation will consist of:

        i. from the training program director, Department Chair and/or Division Chief at the applicant's current institution, verification of competency in all skills, behaviors and procedures considered to compose the Core Privileges of the specialty or subspecialty

of practice;

ii. specific verification of competency in skills, behaviors and procedures considered to exist outside the Core Privileges (Non-Core Privileges) for the specialty or subspecialty of practice as requested by the Credentials Committee when new privilege(s) are granted;

iii. review of practitioner-specific quality data by the Department Chair, Division Chief or Department Quality Officer with the physician 90 days after the initial appointment. If the practitioner is the Chair of a clinical department, review by the Dean of the School of Medicine designee is required;

iv. verification to the Credentials Committee by the Department Chair, Division Chief or Department Quality Officer at the conclusion of the 90 day period that the performance of the practitioner is within acceptable standards and consideration of this verification by the Credentials Committee; if the Department Chair, Division Chief or Dean of the School of Medicine or designee (in the case of a Chair) determines that additional time is needed to complete the Focused Evaluation then the period shall be extended for up to 90 days. The Credentials Committee shall be notified of this extension and shall consider whether this extension shall affect the practitioner's privileges. At the conclusion of this extended period, the Department Chair, Division Chief or Dean of the School of Medicine or designee (in the case of a Chair) shall notify the Credentials Committee of the outcome of the FPPE and the Credentials Committee shall use this information in review of the practitioner's clinical privileges;

b. For practitioners who have clinical privileges in the Medical Center but are seeking to add a new privilege, the Focused Evaluation will consist of:

i. documentation submitted by the Clinical Staff Member and the Department Chair, Division Chief or the Dean of the School of Medicine or Designee (in the case of a Chair) to the Credentials Committee of clinical experience and specialized training to support his or her competency and qualifications; or

ii. in the absence of the information in (i) above, or in addition to that information if requested by the Credentials Committee, the practitioner will undergo a Professional Practice Evaluation (potentially including concurrent proctoring) for an initial period of 90 days based on processes and procedures defined by the applicable Department or Division and acceptable to the Credentials Committee.

2. Focused Professional Practice Evaluation Process – Triggering Events. A Focused Evaluation may also be initiated when a single or sentinel event occurs and/or patterns or trends indicate potentially unsafe patient care. Any member of the Clinical Staff or any other person who believes a practitioner is unable to provide safe, quality patient care may request in writing such an assessment to the Clinical Department Chair, Division Chief, Senior Associate Dean for Clinical Affairs, Medical Director of Quality and Performance Improvement, President of the Clinical Staff, Chair of the Credentials Committee, Dean of the School of Medicine or the Vice President and Chief Executive Officer of the Medical Center.

All such requests shall be forwarded to the Chair of the PPES and to the Clinical Staff Office. The Chair of the PPES shall refer the matter to the appropriate Clinical Department Chair or Division Chief, requesting that he/she assess the practitioner's performance and report back to the PPES. If such requests involve a Clinical Chair, the requests shall be submitted to the Dean of the School of Medicine or designee. The Clinical Department Chair may exercise discretion regarding the need for FPPE based upon his/her direct knowledge of the practitioner, the nature of the concern and the history of prior concerns/complaints regarding that practitioner. The Chair may delegate responsibility for carrying out FPPE to the appropriate Division Chief or Chiefs within the Department. The events, patterns or trends for a Focused Evaluation in this circumstance include both global and department-specific triggers as defined below:

a. Global:

i. a request in writing describing concerns related to the ability of a practitioner to provide safe quality patient care, submitted as described above;

ii. mortality measures: Evidence of a pattern of unexpected death, examples of which may include a severity-adjusted mortality index significantly above that of the institutional peer group, death in low-mortality diagnosis-related groups, and/or assignation of preventable death after departmental mortality review. In some circumstances, a single unexpected death may be considered sufficient to warrant a FPPE;

iii. morbidity measures: Evidence of a pattern of unexpected serious but non-fatal injury, examples of which may include rates of serious adverse events, patient safety indicators, or hospital-acquired complications (including, but not limited to: new onset peri-procedural myocardial infarction, neurologic injury, renal failure, thromboembolism, or injury to vital organs), at a rate significantly exceeding that of the institutional peer group. In some circumstances, a small number of serious complications may be considered sufficient to warrant a FPPE;

iv. sentinel events (as defined by The Joint Commission) if the root cause analysis suggests the event may have been precipitated by cognitive or behavioral deficit of the practitioner;

v. excessive number of patient complaints as determined by Departmental QI evaluations;

vi. Quality report trends and patterns involving concerns about a practitioner's performance, including professional behavior (based on nature and number);

vii. Concerns about practitioner health or fitness to practice, including concerns about substance abuse or other impairment, as determined by the Department Chair, Division Chief or the Physician Wellness Program;

viii. concerns about patterns or trends in rate-based indicators in the Physician Quality Dashboard showing significant variance from the institutional peer group, including but not limited to: (a) rate of unplanned readmission within 30 days after discharge for complication or incomplete management of problem during previous admission (allocation to the appropriate attending physician), (b) use frequency of reversal

agents, (c) severity adjusted length of stay indices, (d) cost per case indices, or (e) final discharge order by 9 AM (F09) and/or discharge by noon (DBN) rates;

ix. excessive aggregate rate of medical record deficiencies;

x. practices that deviate significantly from established clinical practice or operational standards/guidelines established by the Quality, Patient Care or Credentials Committees, e.g. usage of restraints, anticoagulants, DVT/PE prophylaxis, informed consent, infection control policies and procedure, new privilege and low volume practitioner policies;

xi. cases determined through departmental quality/peer review group to warrant FPPE;

xii. initiation of an investigation by the Department of Health Professions or an action taken by the Virginia Board of Medicine, the Virginia Board of Dentistry or the Virginia Board of Psychology and based upon the nature of the complaint and the action taken.

b. Department or Division specific:

i. any area of competency regularly reviewed as a component of an Ongoing Professional Practice Evaluation for which an individual practitioner is outside the Clinical Department or Division benchmark standards, or for whom an unfavorable trend is noted over two cycles of the Ongoing Evaluation; or

ii. other triggers as specifically defined by the Clinical Department Chair or Division Chief for that Department or Division.

c. A Focused Evaluation is time limited, as determined by the Clinical Department Chair or by the Dean of the School of Medicine in instances where the Focused Evaluation involves a Chair. In general, a Focused Evaluation should be completed in 90 days, except as circumstances otherwise warrant (e.g., the need for an external evaluator or a particularly complex evaluation). If after the designated review period, competency assessment is not yet verified, the evaluation may be extended or a different type of evaluation process may be initiated. The evaluation period shall proceed until such time as: (i) satisfactory evidence exists to support the practitioner's competence to perform the requested privilege or (ii) performance improvement has occurred. However, if the Department Chair (or Dean of the School of Medicine, in cases involving a Chair) concludes that satisfactory evidence of competence has not been produced and/or that performance improvement has not occurred, he/she shall recommend to the Credentials Committee a modification of the practitioner's clinical privileges.

d. Information to be considered in a Focused Evaluation may include, but is not limited to: chart reviews, monitoring clinical practice patterns, simulation, proctoring, assessments by internal or external peers, and discussion with other care givers of specific patients (e.g., consulting physicians, nursing or administrative personnel).

e. External sources of information as well as external reviewers may be utilized in the Focused Evaluation process when they are helpful to establish the appropriate standard of care and compliance with that standard. This may include instances where a requested privilege being

considered is a new service that has not been performed regularly in the Medical Center and no internal source can properly evaluate the practitioner's competency, or where a conflict of interest may be raised regarding reviewers within the Medical Center.

f. After completion of the Focused Evaluation, the Clinical Department Chair or Dean of the School of Medicine (in cases involving a Chair) shall report the results to the Credentials Committee. The Credentials Committee will consider the results of the Focused Evaluation in its decision to grant or deny the privileges requested by the individual practitioner.

g. The Department or Division shall maintain all documentation related to Focused Evaluations in a separate quality file for each physician and in a secure location.

3. Ongoing Professional Practice Evaluation Process.

a. Ongoing Professional Practice Evaluations shall begin immediately after the grant of clinical privileges to a practitioner to practice in the Medical Center and provide continuous monitoring of the practitioner's clinical performance. It is the responsibility of each Clinical Department Chair or the Dean of the School of Medicine or designee (in cases involving a Chair) to implement the appropriate process for Ongoing Professional Practice Evaluations within his or her Department as contemplated by this Policy. The Clinical Department Chair or Dean of the School of Medicine or designee may delegate this responsibility to the appropriate Division Chief or Chiefs within the Department.

b. Each Clinical Department will have specific practice-specific metrics including internal and external benchmarking to be tracked for each practitioner within the Department, some of which will be organization wide criteria and some of which will be Department specific criteria. The organization wide criteria (e.g., Physician Quality Dashboard data and global triggers) will be based in principle on the Joint Commission core competencies of patient care, medical knowledge, practice based leaning and improvement, interpersonal and communication skills, professionalism and systems based practice. The Department of Quality and Performance Improvement will work with each Clinical Department to develop the performance information in dashboard format and will provide the dashboard information for the Department or Division to the Department Chair, applicable Division Chiefs and the Credentials Committee every six months. Each Department shall maintain this information in a separate quality file for each physician and in a secure location.

c. Each Clinical Department Chair or Division Chief, as appropriate, will review the physician-specific dashboards as one way to evaluate the performance of practitioners within the particular Department or Division. The Dean of the School of Medicine or designee shall be responsible for evaluation of performance for all clinical chairs. Individual practitioner evaluations will be based on the specified benchmark criteria for the Department or Division as well as other information specific to the practitioner from sources such as periodic chart review, direct observation, monitoring of diagnostic and treatment techniques and/or discussion with other individuals involved in the care of each patient including consulting physicians, assistants at invasive or high risk procedures, nursing, and administrative personnel.

d. If there is uncertainty regarding the practitioner's professional performance, a Focused Evaluation or assessments by internal or external peers of the practitioner may be undertaken in accordance with this Policy or corrective action may be pursued in accordance with Article

VII of the Medical Center Clinical Staff Bylaws, as deemed appropriate.

e. At the time of re-credentialing of an individual practitioner, all of the practice evaluation data will be considered by the Clinical Department Chair, the Division Chief, or Dean of the School of Medicine or designee (in the case of a Chair), as applicable, and the Credentials Committee.

4. Professional Practice Evaluation Subcommittee. The PPES shall:

a. Assure that the Professional Practice Evaluation is conducted in a manner that is objective, equitable and consistent. The Subcommittee shall require that (i) case selection is done by use of pre-selected indicators; (ii) review of cases is performed by committee in accordance with established procedure that has been approved by the Credentials Committee, (iii) follow-up is conducted in accordance with procedures approved by the Credentials Committee and reported to the Medical Center Operating Board Quality Subcommittee.

b. Review regularly and at random, the results of FPPE and OPPE on individual practitioners.

c. Make recommendations to the Credentials Committee regarding the status of the FPPE and OPPE processes in the clinical departments.

d. Make recommendations to the clinical departments as to how they could improve the FPPE and OPPE processes.

e. Review the results of all FPPE and OPPE processes which result in recommendations for restriction of privileges or practice.

f. Submit an annual report to the Credentials Committee concerning compliance with the requirements of this Policy.

g. Review and recommend revision of Medical Center policy regarding Professional Practice Evaluations periodically or as required by regulations or accrediting bodies.

h. Maintain confidentiality of Professional Practice Evaluation data, documents and work products.

Attendance will be kept for meetings of the Professional Practice Evaluation Subcommittee. Members who do not maintain attendance at 50% of the meetings over a six month period will be replaced.

5. Conflict of Interest. A practitioner who is asked to perform a Professional Practice Evaluation may have a conflict of interest if the practitioner may not be able to render an unbiased opinion. An absolute conflict of interest would result if the practitioner were the provider under review. Relative conflicts of interest may be due to a practitioner's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved. However, simply being a member of the same Clinical Department or Division as the practitioner under review may not constitute a conflict of interest. In any case where a practitioner who has been requested to perform a Professional Practice Evaluation believes that he or she may have a conflict of interest or there is any doubt, the practitioner should disclose the situation to the Chair

of the PPES who has the responsibility to determine on a case-by-case basis if a relative conflict or potential relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, then the individual may not participate or be present during the review body discussions or decisions other than to provide specific information requested by the review body.

6. Privilege and Confidentiality. All proceedings, minutes, records and reports of the Professional Practice Evaluation process are privileged and confidential to the full extent authorized by Virginia Code § 8.01-581.17 and are also exempted from production under Section 2.2-3705.1(1) of the Virginia Freedom of Information Act.

   a. Members of the Credentials Committee and the PPES will sign an acknowledgment of the requirements for maintaining the privilege at the time of their appointment and yearly thereafter.

   b. The Medical Center and the clinical departments shall keep in a secure location provider-specific professional practice information that includes (i) performance data for all benchmarked data; (ii) the results of FPPE and OPPE processes; (iii) the practitioner's role in sentinel events; (iv) correspondence to the practitioner regarding practice, performance or corrective action.

   c. The Credentials Committee and PPES shall determine who shall have access to provider specific practice evaluation information.

SIGNATURES:

Robert S. Gibson, M.D., President, Clinical Staff

R. Edward Howell, CEO, UVA Medical Center

DATE: 8/22/13

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