

# **PHSOR Professional Staff Quality Review Policies and Procedures**

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**Purpose:**

To ensure that PHSOR, through the activities of its professional staff, assesses the performance of practitioners who are granted clinical privileges and uses the results of such assessments to improve overall care.

**Goals:**

Ensure that the Professional Staff Quality Review Process is clearly defined, consistent with hospital policies, timely, objective, defensible, and useful. The components to ensure that these elements are met include:

1. Monitoring and evaluating the ongoing professional practice of practitioners with clinical privileges.
2. Creating a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities.
3. Providing accurate and timely performance data for focused and ongoing professional practice review.
4. Promoting efficient use of Practitioner and quality staff resources.

**Article I. Definitions:****1. Peer:**

A “peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance will determine what “practicing in the same profession” means on a case-by-case basis. For quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For detailed specialty-specific clinical issues, a peer is an individual who is well-trained and competent in that specialty area.

**2. Peer review:**

“Peer review” is the objective evaluation of an individual practitioner’s professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner’s performance, the quality of care rendered by a group of professionals or by a system. Peer review is the process for review of practitioner’s professional conduct and/or competence as part of the professional staff’s quality oversight, performance improvement and patient safety responsibilities.

**3. Peer Review Body:**

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The peer review body is a person or committee designated to perform the review of an individual practitioner's performance. The peer review committee is designated by the Medical Executive Committee (MEC) to perform the function of peer review oversight, and to make recommendations for actions to the MEC, as applicable.

#### **4. Practitioner competency framework:**

The practitioner's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six Joint Commission/ACGME general competencies described below:

- a. **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.
- b. **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
- c. **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- d. **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.
- e. **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
- f. **Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

These competencies are further defined in the PHSOR Professional Staff Policies and Procedures.

#### **5. Focused Professional Practice Evaluation (FPPE):**

FPPE is consistently implemented as a means to verify clinical competence for all new professional staff members, newly requested privileges, late career practitioners, and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care.

## **6. Ongoing Professional Practice Evaluation (OPPE):**

OPPE is the ongoing process of data collection for the purpose of identifying professional practice trends that impact quality of care and patient safety. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the two-year membership and privilege renewal cycle. OPPE is conducted every six months.

## **7. Mentoring:**

Mentoring is a process when a Professional Staff member is seeking to arrange individual informal clinical experience or tutoring to meet privilege criteria or to enhance clinical skills. ([LINK to Clinical Competency Assessment Form](#))

## **8. Proctoring:**

Proctoring is a process of independent, objective, direct observation and evaluation of a practitioner's knowledge, skill, and expertise. ([LINK to Clinical Competency Assessment Form](#))

## **9. Conflict of Interest:**

Conflict of interest occurs when personal interests or activities influence or appear to influence actions and decisions. A member of the professional staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. Conflict of Interest may be defined as:

- a) Practitioner involved in the peer review process is the practitioner under review.
- b) Practitioner involved in the peer review process is a direct competitor, partner, or key referral source.
- c) Practitioner involved in the peer review process is a relative of the practitioner under review.

It is the obligation of the Practitioner involved in the peer review to disclose to the peer review body the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis whether a conflict is substantial enough to prevent the practitioner from participating. Multiple leadership roles do not preclude a practitioner from participating in peer review.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the MEC or designee will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

## **Article II. Guidelines for Professional Quality Review:**

1. All professional quality review information is privileged and confidential in accordance with professional staff policies and bylaws, hospital policies, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
2. The affected practitioner will receive feedback.
3. The professional staff will use professional quality review information in making its recommendations to the hospital regarding the credentialing and privileging process.
4. The professional staff will use professional quality review information to develop performance improvement plans as applicable.
5. The hospital will keep professional quality review information confidential. This information may include but is not limited to:
  - a. Performance data for all dimensions of performance measured for that individual practitioner.
  - b. Peer review documentation related to sentinel events, significant incidents, or near misses.
  - c. Commendations or concerns related to practice performance or professional conduct.
  - d. Correspondence, meeting summaries or letters to practitioners regarding professional quality review activities.
  - e. Performance Improvement and/or Action Plans.
6. Final determinations of the Department Chair/Division Chief/ peer review committee and any subsequent actions are considered part of the practitioner's quality file.
7. Peer review information in the practitioner's quality file is available only to authorized individuals as specified in the PHSOR Professional Staff Policies and Procedures.

The peer review process does not apply to the performance of non-privileged students, residents, and fellows. Their performance is assessed by the policies and procedures of their training program and the PHSOR Graduate Medical Education Committee. A Member's supervision of a non-privileged student, resident, or fellow may be addressed in the context

of peer review.

### **Article III. Peer Review (Individual incident)**

[Link to Professional Staff Leader Toolkit for forms and information](#)

#### **1. Purpose**

The primary purpose of peer review is to ensure that patients receive quality services that meet professionally recognized standards of health care via an objective, non-judgmental, consistent, and fair evaluation by the Professional Staff.

#### **2. Objectives**

Peer review will be conducted in a timely manner. The goal is for routine cases to be completed within 60 days from the date the chart is reviewed by the Quality Management (QM) staff. Exceptions may occur based on case complexity or reviewer availability.

Peer review is conducted on an ongoing basis through multiple sources, and reported to the appropriate Department chair/committee for review and action. Cases for individual review are identified by:

- a) Unusual Occurrence Reports (UORs)
- b) Patient/family/staff complaints
- c) Sentinel events/adverse events
- d) As required by regulatory agencies
- e) Referral from clinician(s), Morbidity and Mortality conferences, Risk Management
- f) Any other legitimate source of concern as determined by Professional Staff Leadership
- g) Noncompliance with Professional Staff Bylaws, Policies and Procedures or regulatory agency requirements
- h) Concerns specifically due to Disruptive Behaviors.

#### **3. Process**

- a) Case identification and screening: cases are identified through multiple sources (see above).
- b) Quality Management Coordinators (QMCs) will review with Department Chairs to identify if the incident should go through the peer review process.
- c) QMC, along with Department Chair when applicable, assigns initial reviewer when case is determined to require practitioner review.
- d) Practitioner reviewer performs case review and completes appropriate section of the Peer Review Form within two weeks of assignment.



- e) Practitioner Reviewer returns form to QMC who places the review on the Professional Quality Review Committee (PQRC) agenda, as applicable.
- f) Completed reviews indicating ‘No issue/concern’ are scanned into the practitioner’s quality file (MSOW).
- g) If reviews indicate ‘some issue/concern,’ the Department Chair is responsible to follow-up with the involved practitioner and determine next steps. Options include:
  - a. Discussion with provider and no further action (document on peer review form)
  - b. Documented collegial conversation (document on peer review form)
  - c. Referral to PQRC with recommendation
- h) The Reviewer will present the case to the committee and, if applicable, the practitioner involved in the case may request to appear at the PQRC meeting. Alternatively, the PQRC may request the practitioner provide written clarification or be present to clarify.
- i) The members of the PQRC discuss the case and determine any needed follow-up actions.
- j) The attending practitioner is notified in writing of the outcome.
- k) The PQRC is a non-disciplinary body, and as such any PIPs developed must be voluntarily agreed to. The PIP developed by the PQRC is communicated to the MEC for review.
- l) Non-compliance with PIP will require escalation to the MEC for their recommendation-
- m) All recommended coaching; education or other corrective measures will be communicated to the practitioner, and will be tracked accordingly.
- n) QMC/MSO will enter the results of all final review findings into the practitioner’s quality file in MSOW.

#### **4. Circumstances Requiring External Peer Review (Outside of the PHSOR Acute Care Ministries)**

The Department Chair/Division Chief, MEC, OMEC, or peer review committee will make determinations on the need for external peer review (Medical Resource Network (MRN) or equivalent). Circumstances requiring external peer review may include the following:

- a) Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or professional staff committees and conclusions from this review will directly affect a practitioner’s membership or privileges.
- b) Lack of internal expertise: when no one on the professional staff has adequate expertise in the specialty under review; or when the only practitioners on the professional staff with that expertise are determined to have a conflict of interest regarding the practitioner under review.

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- c) Miscellaneous issues: when the professional 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.
- d) The Department Chair/Division Chief, MEC, OMEC, or peer review committee may require external peer review in any circumstances deemed appropriate by any of these bodies.

## **5. Participants in the Review Process**

Participants in the review process will be selected according to the PQRC Charter, by Department and/or Professional Staff Leadership. Clinical support staff will participate in the review process if deemed appropriate. The peer review body will consider the views of the practitioner whose care is under review prior to making a final determination.

## **6. Oversight and Reporting**

Direct oversight of the peer review process is delegated by the MEC to the Department Chair/Division Chief and the PQRC. Results will be reported to the OMEC through the MEC.

## **Article IV. Focused Professional Practice Evaluation (FPPE)**

### [Professional Staff Leader Toolkit Link](#)

#### **1. Purpose**

To define a process to evaluate performance of all Practitioners when 1) new privileges are requested, or 2) when there is a question regarding a currently privileged Practitioner's ability to provide safe, high quality patient care.

#### **2. Objectives**

To conduct appropriate monitoring of the care delivered by the professional staff and to promote safety and high quality health care for patients.

FPPE may be initiated by the following bodies: Oregon Credentials Committee (OCC), Department Chair, OMEC, MEC, PQRC or a special committee of the Professional Staff.

FPPE is initiated when:

- a) New privileges are requested.
  - An applicant applying for membership/privileges
  - A member at a primary site requesting new privileges.

- A member requesting privileges at a non-primary facility.

FPPE is initiated/considered when:

- b) A question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner's ability to provide safe, high quality patient care. For example: when a trigger is exceeded and preliminary review indicates a need for further evaluation.
- c) All objective criteria have been met at initial privileging and re-privileging except minimum case volume.
- d) On or after the age of 70 during the credentialing and re-credentialing process.

FPPE (often called 'FPPE for cause') may be conducted whenever concerns are raised about a practitioner's clinical practice or professional conduct. Triggers that may initiate FPPE for cause:

- a) Pattern of reported concerns from a practitioner or Hospital employee
- b) Identification by a Professional Staff committee of a clinical trend or specific cases that require further review
- c) Pattern of patient complaints determined to require Practitioner review
- d) A Department Chair determination that OPPE data reveal a practice pattern or trend that requires further review
- e) A trend of noncompliance with Professional Staff bylaws, policies, or other policies and/or failure to follow adopted clinical guidelines
- f) Identification of cases as litigation risks
- g) Referrals with concerns about medical necessity
- h) Sentinel events as defined in the GOP sentinel events policy
- i) Repeated failure of a Practitioner to fulfill his/her duties
- j) Multiple diagnostic errors/complications
- k) Repeated failure of a Practitioner to provide adequate care
- l) Unusually high complication rate
- m) Practitioner failure to respond to Peer Review inquiries
- n) Noncompliance with Professional Staff Expectations including but not limited to concerns specifically due to disruptive behavior. Disruptive behavior includes, but is not limited to:
  - i. Threatening or abusive comments;
  - ii. Profanity or similarly offensive language;
  - iii. Demeaning behavior such as name-calling;
  - iv. Criticizing other peers or staff members in front of patients and or other staff;
  - v. Racial or ethnic jokes or comments;
  - vi. Inappropriate physical conduct, sexual or otherwise;
  - vii. Sexual comments or innuendo

- viii. Refusal to cooperate with other workforce or professional staff members;
- ix. Refusal to abide by the organizational policies, Professional Staff Policies and Procedures, and Professional Staff Bylaws
- x. Refusal to perform patient care responsibilities

### 3. Process

Department Chairs, OCC and/or MECs shall consider relevant monitoring requirements when making their recommendations regarding clinical privilege requests and may modify the monitoring requirements if an applicant's credentials indicate that additional or different monitoring may be required. The FPPE monitoring plan will be specific to the requested privilege or group of privileges at each facility when:

- a. A new practitioner requests privileges
- b. A current practitioner requests privileges at a secondary site
- c. A current practitioner requests new privileges
- d. Concerns are raised about a practitioner's clinical practice or professional conduct.

The requirements shall specify either a defined time period for monitoring or a defined number of cases.

- 1) Implement FPPE for new and current professional staff who request privileges or when FPPE for cause is appropriate. FPPE can include:
  - a) Chart reviews, both concurrent and/or retrospective.
  - b) PhysicianFocus reports
  - c) Simulation.
  - d) Concurrent observation/proctoring of a specified number of cases or for a specified period.
  - e) Discussion with other individuals involved in the care of the new member's patients.
  - f) Practitioner Evaluation Forms (e.g. Clinical Competency Assessment Form, Clinical Competencies Evaluation form, etc.).
  - g) For AHPs, six month evaluation by sponsoring Practitioner. In addition, FPPE methods may include review or proctoring by the sponsoring Practitioner.
- 2) Assign evaluator. Evaluator assesses all aspects of the care provided through review of medical record documentation, interviews with the care team as appropriate, or by direct observation. Upon completion of assessment, the evaluator completes any relevant forms and returns to the medical staff office to be included in the credentialing packet that is forwarded to the Department Chair.
- 3) Department Chair reviews documentation and makes a recommendation to continue,

- modify, or revoke clinical privileges.
- 4) Department Chair recommendations, based on review of the assessment documents, are reported to the OCC.
  - 5) Department Chair or designee communicates with the Practitioner and provides feedback on the results and recommendations. Each practitioner will be notified of his/her performance and outcome(s) following FPPE. A letter is forwarded to the practitioner including, but not limited to, the following:
    - a) Findings and outcome of FPPE.
    - b) Specific actions, if any, that need to be taken by the practitioner to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed.
    - c) If the focused review is complete or will continue (duration will be specific if the focused review will continue).
    - d) Results are maintained in the Practitioner's Quality File.
  - 6) If by the end of the period of focused evaluation the practitioner's activity/volume has not been sufficient to meet the requirements of FPPE:
    - a) The practitioner may voluntarily resign the relevant privilege(s), or
    - b) The practitioner's FPPE will be considered complete at re-appointment, and evaluation of the practitioner's performance will be conducted through the OPPE process.
    - c) If the practitioner has sufficient volume of the privileges in question at another local facility, peer references and/or quality assessment data specific to the privilege/procedure may be obtained and used as supplemental data.
  - 7) FPPE may be extended at the discretion of the responsible professional staff Department Chair or designee or committee if concerns noted.
  - 8) Applicant's right to appeal adverse decisions is defined in the PHSOR Policies and Procedures, Fair Hearing Plan.
  - 9) Suggested Meeting Strategies when FPPE for cause is related to a behavioral issue:
    - a) First Incident - Meet with the Practitioner to discuss the matter, inform Practitioner of the issue and action required to correct it, and note the issue, the meeting, and required action in the quality file.
    - b) Second Incident – Issue a written reprimand to the practitioner, and inform the practitioner, in writing, that if there is a future incident, the matter will be referred to the MEC for appropriate sanction under the corrective action PHSOR policies and procedures. Prepare a memorandum for the practitioner's quality file detailing the issue, the meeting and the action taken.
    - c) Third Incident – Department Chair or designee to refer the matter to the MEC with a recommendation that formal action be taken in accordance with the corrective action section of the PHSOR policies and procedures.

- d) Where there is serious misconduct, the issue is referred to the MEC for corrective action immediately, disregarding the series of steps outlined above.

If the findings identify potential patient care concerns the PQRC, OCC and/or MEC, in conjunction with the Department Chair, will evaluate the results and will develop a written performance improvement plan. Methods identified to resolve performance issues shall be clearly defined.

Examples of improvement methods may include but are not limited to:

- a) Necessary education
- b) Proctoring and/or mentoring
- c) External Case Review
- d) Other FPPE
- e) Counseling
- f) Practitioner Assistance Program
- g) Disciplinary action to include, but not limited to suspension and /or revocation of membership and/or privileges

#### **4. Oversight and Reporting**

Direct oversight of the FPPE process is delegated by the MEC to the Department Chair/ Division Chief and the PQRC/OCC. Results will be reported to the OMEC through the MEC.

### **Article V. Focused Professional Practice Evaluation (FPPE) for Practitioners $\geq 70$ (Late Career)**

#### **1. Purpose**

Professional Staffs are obligated to assess each practitioner's capacity to perform all requested privileges. The natural aging process and specific diseases have the potential to adversely affect the ability of practitioners to perform some or all of their requested privileges. Therefore Professional Staffs are obligated to assess the impact of aging on all practitioners' capacity to perform requested privileges. The Professional Staff adopts this policy to protect patients from harm, support practitioners and protect their rights.

#### **2. Objectives**

It is the policy of the Professional Staff that the Medical Executive Committee (MEC) specifically considers, on an ongoing basis, the abilities, competencies, and health status (ability

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to perform) of each practitioner who has clinical privileges in accordance with the Professional Staff bylaws, policies and procedures. This policy applies to all members, applicants, and Allied Health Professionals at PHSOR.

### **3. Process for age 70- 74:**

Upon application for initial appointment or reappointment on or after the age of 70, or upon the request of the MEC for cause, regardless of age, each practitioner requesting privileges shall, as a required element of his/her application, undergo a focused review of his/her clinical performance. The Focused Professional Practice Evaluation (FPPE) will include the following elements:

- a) A total of three Clinical Competencies Evaluations (CCEs) of the applicant's clinical performance by professional staff members, trainees, advanced practice professionals, nurses or other hospital staff who are in a position to evaluate the applicant's clinical performance (*preferably from individuals in addition to peer reference submitters*).
- b) The Medical Staff Office will coordinate and submit CCE references as part of a six month FPPE for initial appointments and/or "for cause" upon the request of the OCC and/or MECs.

### **4. Process for age 75 and older**

Upon application for initial appointment or reappointment on or after the age of 75, or upon the request of the MEC for cause, regardless of age, each practitioner requesting privileges shall, as a required element of his/her application, undergo a focused review of his/her clinical performance. The FPPE will include the following elements:

- a) A total of three CCEs of the applicant's clinical performance by professional staff members, trainees, advanced practice professionals, nurses or other hospital staff who are in a position to evaluate the applicant's clinical performance (*preferably from individuals in addition to names submitted by practitioner for peer references*).
- b) A comprehensive Health Assessment arranged and paid for by the practitioner using the 'Health Assessment for Practitioners Age 75 and older and for Cause' form ([Health Assessment Form link](#))
- c) The individual performing the examination must be approved in advance by the OCC, or their designee.
- d) Failure to complete the required examination within 90 days of notification to the practitioner will be deemed as a voluntary resignation of the member's Professional Staff membership and privileges.

### **5. Oversight and Reporting**

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- a) If the findings identify potential patient care concerns, the PQRC, or OCC, and/or MEC will evaluate the results and will recommend further evaluation to include, but not limited to:
  - i. Proctoring
  - ii. Mentoring
  - iii. Retrospective Review of Cases
  - iv. External Case Review
  - v. Other FPPE
  - vi. Disciplinary action to include, but not limited to suspension and /or revocation of membership and/or privileges

## **Article VII. Ongoing Professional Practice Evaluation (OPPE)**

### **1. Purpose**

OPPE allows the identification of practice trends that impact quality of care and patient safety between reappointment cycles.

### **2. Objectives**

The framework by the American College of Graduate Medical Education is utilized to define expectations of performance, measurements of performance, and performance feedbacks. These elements may include:

#### Patient Care

- a) Mortality
- b) Readmissions
- c) Length of stay
- d) Evidence based care measures pertinent to specialty
- e) Patient/staff concerns
- f) Patient satisfaction survey results

#### Medical-Clinical Knowledge

- a) Division Chief/Section Chair/Department Chair recommendation
- b) Professional Staff Peer Review
- c) Certification/recertification
- d) Evidence based Continued Medical Education

#### Practice-based Learning Improvement

- a) Professional Staff Peer Review



- b) Certification/recertification
- c) Evidence based CME

#### Interpersonal and Communication Skills

- a) Patient/staff concerns
- b) Patient satisfaction survey results
- c) Letters/phone calls to Administration/staff
- d) Division Chief/Section Chair/Department Chair recommendation

#### Professionalism

- a) Patient satisfaction survey results
- b) Patient/staff concerns
- c) Letters/phone calls to administration/staff
- d) Division Chief/Section Chair/Department Chair recommendation
- e) Education
- f) Responsiveness

#### Systems-based Practice

- a) Outcomes
- b) Length of stay
- c) Mortality
- d) Readmissions
- e) Complications
- f) Evidence based care measures pertinent to specialty
- g) Professional staff peer review and recommendations

### **3. For Current OPPE indicators see [Professional Staff Leader Toolkit](#)**

#### **3.1 Process**

- a) Collection of Data.
  - i. OPPE is conducted on an ongoing basis, but more frequent than annually.
  - ii. OPPE shall be compiled by Quality Management Staff.
  - iii. The OPPE report is a starting point for identifying improvement opportunities and not considered definitive until further evaluation, including FPPE if appropriate. This evaluation is used to understand differences in performance relative to expectations and is discussed with the practitioner involved.
  - iv. Department Chairs are involved in the identification of the performance measures that are used to evaluate practitioners of the Professionals Staff and AHPs assigned to their Departments, recommended by the MEC and approved by the OMEC.

- v. Depending upon the type of practice and available data, measures are quantitative, qualitative or a combination of both.

### **3.2 Oversight and Reporting**

- a) Review of Data:
  - i. The Department Chair or his/her designee are provided with practitioner specific data and will then perform a final review, identify any variances in clinical trends or patterns, make recommendations, and subsequently sign off on the OPPE report.
- b) If the Department Chair or his/her designee determines that FPPE is required, the process outlined in FPPE for cause will be followed. The information resulting from the evaluation may be used to provide recommendation to PQRC, OCC or MEC regarding further evaluation or action consistent with the PHSOR Policies and Procedures. Based on analysis, several possible actions could occur, including but not limited to:
  - i. Determine that the practitioner is performing well or within desired expectations and that no further action is warranted
  - ii. Determine that an issue exists that requires a focused evaluation
  - iii. Recommend removing the privilege because it is no longer required
  - iv. Remove the privilege, which suspends the data collection, and notify the practitioner that if they wish to reactive it they must request a re-activation
  - v. Determine if the zero performance should trigger a focused review (MS.4.30 EP 5)
  - vi. Determine if the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients
- c) Professional Staff practitioners who do not admit to the hospital or are in a specialty that does not provide hospital care as an attending Practitioner will be responsible for providing the Department Chair or designee with information that will allow the committee to make an informed re-credentialing decision. Criteria may include:
  - i. Patient satisfaction survey results
  - ii. Patient/staff concerns
  - iii. Letters/phone calls to administration/staff
  - iv. Other relevant criteria as determined by the Division Chief/Section Chair/Department Chair
  - v. Data from other facilities as produced by the Practitioner
- d) At the time of reappointment the Quality file with the reappointment packet is reviewed by the Department Chair and a recommendation is made to all applicable committees as identified in the PHSOR Policies and Procedures. Documentation of his/her review and recommendations regarding reappointment will be included in the quality file.

## **Article VIII. Proctoring Guidelines [Link to Clinical Competency Assessment Form](#)**

### **1. Defined**

Independent, objective, direct observation and evaluation of a practitioner's knowledge, skill, and expertise in new technology, high risk procedures or infrequently performed procedures and initially granted privileges without a current professional performance record at the hospital. Applicants meet all objective standards for Professional Staff Membership and privileges, other than proctoring requirements.

### **2. Applicability**

Initial privileging when privilege criteria require proctoring, usually in cases of new technology or for high-risk or infrequently performed procedures, when recommended on review of a concern identified through Ongoing or for Focused Professional Practice Evaluation of initially granted privilege.

### **3. Role/Qualification of Proctor**

- a) Independent and unbiased monitor, with privileges in area requested, to evaluate the technical and cognitive skills of another practitioner. Outside experts may be granted temporary privileges for proctoring purposes when the expertise is not available within the Professional Staff.
- b) Expertise to judge technical and cognitive skills, and quality of care delivered
- c) Represents and responsible to Hospital, Professional Staff and Community Ministry Board as one of the quality management activities of the Professional Staff
- d) PHSOR Professional Staff Policies and Procedures state that members granted privileges in new procedures are expected to assist in the training and proctoring of other members.
- e) The individual may receive a fee from the practitioner or the Hospital.

### **4. Proctoring Process**

- a) Proctor must engage in direct observation of specified number of procedures/cases and evaluate all aspects of the care provided.
- b) Proctor must be identified at time of scheduling of the case or on admission.
- c) Clinical Competency Assessment forms are provided to the proctor. Modifications to standardized forms, if needed, should be limited.
- d) Clinical Competency Assessment forms should be filled out immediately after each observed procedure/case and submitted to the Medical Staff Office.
- e) Upon completion of proctoring, the forms and an optional confidential report should be forwarded to the Department Chair, whose recommendation is forwarded to the

OCC. Recommendation may be that proctoring was successfully completed or for further training, proctoring or conditions on privilege request.

- f) Applicant's right to appeal adverse decisions is defined in the PHSOR Policies and Procedures, Fair Hearing Plan.
- g) In the event of observed substandard medical care that is harmful to the patient, the proctor should contact the Department Chair or designee as soon as possible and ask the practitioner to stop the substandard actions, or intervene and document the action taken.

## **Article XI. Mentoring Guidelines ([Link to Clinical Competency Assessment Form](#))**

### **1. Defined**

The mentoring process is when a Professional Staff members seeking to arrange individual informal clinical experiences or mentoring to meet privileging criteria or to enhance clinical skills. Additional clinical experience for professional development may be provided or obtained through a mentoring arrangement, either as defined in privileging criteria or with a plan developed with an experienced professional in a specific practice area or procedures. Department Chair and OCC approval is required.

### **2. Applicability**

Initial privileging when privilege criteria require mentoring, when Member seeks to obtain additional clinical experience, when recommended on review of a concern identified through Ongoing Professional Practice Evaluation or for Focused Professional Practice Evaluation of initially granted privilege. Mentee must have the ability to meet applicable clinical privilege criteria with successful clinical experience/mentoring.

### **3. Role/Qualification of Mentor**

- a) Recognized expert, knowledgeable and skilled, in clinical area identified for additional clinical experience/mentoring. Outside experts may be granted temporary privileges for mentoring purposes when the expertise is not available within the Professional Staff.
- b) Mentor is responsible to provide guidance, direction and support to practitioners for professional development.
- c) Expertise to judge technical and cognitive skills, and quality of care delivered.
- d) The Practitioner doing the material aspects of the procedure shall be identified and provide the informed consent.
- e) Represents and responsible to Hospital, Professional Staff and Community Ministry Board as one of the quality management activities of the Professional Staff
- f) PHSOR Professional Staff Policies and Procedures state that members granted privileges in new procedures are expected to assist in the training and proctoring of

other members.

- g) The individual may receive a fee from the practitioner or the Hospital.

#### **4. Mentoring Process**

- a) Unless specified by privilege criteria, a Clinical Experience/Mentoring Plan must be approved by the Department Chair and OCC. The plan must include the following elements: participants, goals and objectives, clinical experience specifics (include patient care responsibilities, involvement in clinical procedures (observation, assistance, and primary performance), documentation, evaluation methods/measurements of success, length of training. Mentoring may occur at other facilities, but requirements for assessment of mentoring experience may be required at Providence facility.
- b) Mentor must be identified at time of scheduling of cases for procedures requiring mentoring. Mentor will be listed as primary surgeon.
- c) Clinical Competency Assessment forms are provided to the mentor. Modifications to standardized forms, if needed, should be limited.
- d) Clinical Competency Assessment forms should be filled out immediately after each mentored procedure/case and submitted to the Medical Staff Office.
- e) Upon completion of mentoring, the forms and an optional confidential report should be forwarded to the Department Chair, whose recommendation is forwarded to the OCC. Recommendation may be that mentoring was successfully completed or for further training or proctoring or conditions on privilege request.
- f) Applicant's right to appeal adverse decisions is defined in the Policies and Procedures, Fair Hearing Plan (Article X).
- g) In the event of observed substandard medical care that is harmful to the patient, the mentor should contact the Department Chair or designee as soon as possible and ask the practitioner to stop the substandard actions or intervene and document the action taken.
- h) Both Practitioners must be identified to the patient and information on the arrangements provided. The Practitioner doing the material aspects of the procedure shall be identified and provide the informed consent.

#### **Article XII. Indemnification Procedure**

Indemnification protection and professional liability coverage may be provided through PHSOR policy for Professional Staff members participating in mentoring, proctoring or other quality assurance and credentialing functions. Indemnification may be provided to non-Professional Staff members by contract. Professional liability coverage for a non-member may be provided through a part-time, non-benefited employee position or as a temporary appointment to a Quality or Credentialing Committee.

### **Article XIII. Disclaimer**

These clinical experience/mentoring arrangements are informal and are not in any way associated with the hospitals' medical education program. The arrangements are between a Member of the Professional Staff and another Member or a non-Member professional colleague. There is no certification of the quality or outcome of the clinical experience/ mentoring arrangement from the Hospital or Professional Staff. Neither the Hospitals nor the Professional Staff organization are involved in any way with payment or reimbursement arrangements involved in any such individual informal clinical experience/mentoring plan.

Indemnification protection coverage is provided through PHS policy for Professional Staff members participating in mentoring, proctoring or other quality assurance and credentialing functions. Indemnification may be provided to non-Professional Staff members by contract. Professional liability coverage for a non-member may be provided through a part-time, non-benefited employee position or as a temporary appointment to a Quality or Credentialing Committee.

### **Article VX. Related Documents (Link to all)**

- [PHSOR Professional Staff Bylaws](#)
- [PHSOR Professional Staff Policies and Procedures](#)
- [PHSOR Allied Health Professional Policies and Procedures](#)
- [Joint Commission Accreditation Standards: Medical Staff](#) (login required, see a Quality Management Coordinator at your facility)
- [PHS Code of Conduct](#)
- [Professional Staff Expectations](#)
- [Professional Staff Leader Toolkit Link](#)
  - Forms for Peer Review/OPPE/FPPE
  - OPPE Indicator list
  - Professional Quality Review Committee (PQRC) Charter
  - PHS Physician attribution policy
  - Performance Improvement Plan Templates
  - Disruptive Behavior Toolkit
  - Clinical Competency Evaluation Form (under 'FPPE Templates')
- [Clinical Competencies Evaluation Form](#)

### **Article XV. Authority**

This policy is based on the statutory authority of the Health Care Quality Improvement Act (HCQI) of 1986 42 U.S.C. 11101, et seq. and ORS 41.675 & 41.685.

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.