Purpose: Practitioner Performance Review

Policy Number: OP 10-10.05
Chapter: Operations
Effective Date: June 2012
Approval Date: April 2012
Supersedes: June 2009

Applicable to
- VUH
- Children’s Hospital
- VMG
- VMG Off-site locations
- VPH
- VUSN
- VUSM
- Other:

Team Members Performing
- All faculty & staff
- Faculty & staff providing direct patient care or contact
- MD
- House Staff
- APRN/PA
- RN
- LPN
- Other: MD and all practitioners with privileges

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Specific Education: YES

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I. Purpose:

To provide guidelines relative to requirements for professional practice evaluation.

II. Policy:

All members of the Medical Staff and Professional Staff with privileges will undergo an initial phase of focused professional practice evaluation (FPPE) with granting of new privileges (new hire or requesting additional privileges). All members of the Medical Staff and Professional Staff with privileges will undergo regular ongoing professional practice evaluation (OPPE) throughout the appointment cycle.

III. Definitions:

A. Focused Professional Practice Evaluation (FPPE):

FPPE is a period of focused evaluation of a provider’s performance. It requires the assignment of a proctor, usually a peer, practicing in the same profession and who has expertise in the appropriate subject matter. The proctor must have an understanding of the provider’s delineation of privileges. FPPE must be time-limited and consistently implemented according to a defined plan of monitoring set forth by the department and approved by the medical staff.

B. Ongoing Professional Performance Evaluation (OPPE):

OPPE is a continual process to evaluate a provider’s practice, identify professional practice trends that impact quality of care and patient safety and to validate on-going competence for existing privileges. The process must be clearly defined with quality data measures determined by the department and approved by the medical staff.

C. Medical Staff:

All licensed physicians and dentists who hold an academic appointment in the Vanderbilt University School of Medicine, and are privileged to attend patients in the Vanderbilt University Hospital (VUMC), Monroe Carell Jr. Children’s Hospital at Vanderbilt (Children’s), the Vanderbilt Psychiatric Hospital (VPH) and Vanderbilt Medical Group (VMG) clinics, as permitted by Medical Staff category and individual clinical privileges.
D. Professional Staff with Privileges:

Non-Medical Staff clinical professionals who are granted privileges to provide direct patient care to patients of VUMC, exercising independent judgment within specific documented areas of professional competence, under a defined degree of supervision by a member(s) of the Medical Staff consistent with applicable law.

E. Center for Advanced Practice Nursing and Allied Health (CAPNAH):

The Director of CAPNAH, in collaboration with applicable leaders, will designate an APRN leader or Allied Health representative to facilitate the FPPE/OPPE process for all privileged professional staff.

F. Confidentiality:

Access to credentials files is limited to the following:

1. Appropriate Provider Support Services staff;
2. Members of the Credentials Committee;
3. VUMC Legal Counsel;
4. VUMC Office of Risk Management;
5. Department/Division Chiefs of the physician’s specialty;
6. The Chief of Staff;
7. Deputy Vice Chancellor for Health Affairs;
8. Chairman, Medical Center Medical Board;
9. Chief Medical Officer;
10. VMG Chief Quality Officer; and
11. Others who may be otherwise authorized.

These files shall be privileged pursuant to TCA §63-5-217.
IV. **Specific Information Provider Classification:**

A. **Medical Staff (FPPE):**

1. An FPPE is required for all newly privileged medical staff and existing staff approved for new privileges. FPPE begins at the time privileges are granted. Provider Support Services send the FPPE form to the Clinical Service Chief who appoints one or more proctors to monitor the provider and submit a report to the Clinical Service Chief at the end of the initial six month work period. The proctor is chosen based on:

   a. His/her seniority/leadership position in the new practitioner’s area of practice; and

   b. The likelihood that the practice pattern of the proctor will overlap with that of the new practitioner so that there will be opportunity for personal interaction, real time observation of care, and/or shared care of patients, e.g., cross-covering, sequential care, or procedural assistance.

2. The practitioner’s delineation of privilege list is made available to the proctor.

3. In preparing the report to the Clinical Service Chief, a proctor may use direct observation, retrospective medical record review, over-reads, procedure/surgery case lists as well as informal reviews with peers, house staff, and/or nursing service personnel to reach his/her conclusion.

4. Four months after the effective date of the provider’s new privileges, the Provider Support Services office sends a reminder to the proctor(s) (with a copy to the Clinical Services Chief), noting that a proctor’s report is due to the Credentials Committee.

5. The Clinical Service Chief reviews the proctor’s report as well as quality and practice data from the ongoing professional practice evaluation.

6. The proctor’s report and recommendations are submitted to the Credentials Committee for review.

7. The proctor’s report becomes a part of the credentials file.
8. If concerns with a practitioner’s professional practice are identified, the Clinical Service Chief may request a time-limited or volume-driven period of proctor-supervised, focused review.

9. Triggers requiring initiation of FPPE include but are not limited to:
   a. Events that are detrimental to the delivery of patient care, patient safety, or to the safety of others;
   b. Practice patterns and/or quality metrics that are below applicable professional standards;
   c. Unethical or illegal behavior;
   d. Actions that are contrary to the Bylaws, Rules and Regulations, or Policies and Procedures of the Medical Staff or actions that are disruptive to the operations of VUMC.

B. Medical Staff - OPPE:

1. Quality metrics are collected continuously for all privileged practitioners. Metrics are summarized, compared to peer metrics, and forwarded to the provider’s Clinical Service Chief or designee a minimum of three (3) times during the two year appointment cycle.

2. At the time of the two (2) year reappointment cycle, the quality metrics are available for review by the Clinical Services Chief and the Credentials Committee.

C. Professional Staff with Privileges – FPPE:

1. An FPPE is required for all newly hired professional staff and existing staff approved for new privileges. At the time privileges are grants, Provider Support Services sends the FPPE form to the Clinical Service Chief and/or CAPNAH Leadership who then appoints one or more proctors to monitor the practitioner and submit a report at the end of the initial six-month period.

2. The proctor is chosen based on:
   a. His/her seniority/leadership position in the new practitioner’s area of practice; and
b. The likelihood that the practice pattern of the proctor will overlap with that of the new practitioner so that there will be opportunity for personal interaction, real-time observation of care, and/or shared care of patients, eg. Cross-covering, sequential care, or procedural assistance.

3. The practitioner’s delineation of privilege list is made available to the proctor.

4. In preparing the report to the Clinical Service Chief, supervising physician, and/or CAPNAH leader, a proctor may use direct observation, retrospective medical record review, over-reads, procedure case lists as well as informal reviews with peers, house staff, and/or nursing service personnel to reach his/her conclusion.

5. Four months after the effective date of the provider’s new privileges, the Provider Support Services office sends a reminder to the proctor(s) (with a copy to the Clinical Service Chief, and/or CAPNAH leader), noting that the proctor’s report is due to the Credentials Committee.

6. The Clinical Service Chief and/or CAPNAH leader reviews the proctor’s report as well as quality and practice data from ongoing professional practice evaluation.

7. The proctor’s report and recommendations are submitted to the Credentials Committee for review.

8. The proctor’s report becomes a part of the credentials file.

9. If concerns with a practitioner’s professional practice are identified, the Clinical Service Chief in collaboration with CAPNAH leader may request a time-limited or volume-driven period of proctor-supervised, focused review.

10. Triggers requiring initiation of FPPE include but are not limited to:

   a. Events that are detrimental to the delivery of patient care, patient safety, or to the safety of others;

   b. Practice patterns and/or quality metrics that are below applicable professional standards;
c. Unethical or illegal behavior;

d. Actions that are contrary to the Bylaws, Rules and Regulations, or Policies and Procedures of the Medical Staff or actions that are disruptive to the operations of VUMC.

D. Professional Staff with Privileges – OPPE:

1. OPPE can include both subjective and objective quality metrics that involve direct observation, retrospective medical record review, over-reads, procedure/surgery case lists, quality data, and interviews with peers, house staff, and/or nursing service personnel.

2. OPPE is performed a minimum of three (3) times during the two-year appointment cycle.

3. OPPE documentation is made available for review by the Clinical Service Chief or CAPNAH Leadership designee and the Credentials Committee.

E. Additional:

1. All FPPE/OPPE reports are maintained in the credentials file in the Provider Support Services office.

2. Components of FPPE/OPPE should be practice specific and cover six general competencies:

   a. Patient Care;

   b. Medical/clinical knowledge;

   c. Systems-based practice;

   d. Practice-based learning and improvement;

   e. Interpersonal/communication skills; and

   f. Professionalism.
V. References:


- MS 01 Medical Staff Bylaws
- MS 02 Medical Staff Rules and Regulations
- MS 03 Medical Staff Policies and Procedures


http://www.mc.vanderbilt.edu/diglib/http://www.mc.vanderbilt.edu/diglib/ Medical Staff Standards MS.08.01.01; MS.08.01.03


Joint Commission Resources. Are you on board with The Joint Commission’s FPPE/OPPE requirements? Hospital Peer Rev. 2009; 34(12): 137-41.


VI. Endorsement:

Operations Policy Committee April 2012

Medical Center Medical Board April 2012

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David Posch 5/10/2012
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