Texas Health Harris Methodist Hospital SOUTHLAKE	**Policy Area:** Medical Staff and Quality
Name of Policy: Professional Practice Evaluation	**Replaces Policy Dated:** June 20, 2018
Pages: 4	**Effective Date:** April 21, 2021

I. PURPOSE

To establish the process whereby the Texas Health Harris Methodist Hospital Southlake (THSL) Medical Staff evaluates the current and ongoing privilege –specific competency of practitioners granted clinical privileges.

II. POLICY

A. THSL Medical Staff, as part of its ongoing commitment to quality, shall evaluate the competency and professional performance of all credentialed practitioners granted clinical privileges or practice prerogatives (hereinafter referred to as "Privileges").

B. Definitions

1. Focused Professional Practice Evaluation (FPPE): A time-limited period not to exceed six (6) months whereby the Medical Staff evaluates the competency and professional performance for practitioners with initially granted privileges, modification of existing privileges or when concerns are raised regarding an existing practitioner's ability to provide safe and quality patient care.

2. Ongoing Professional Practice Evaluation (OPPE): The process whereby the Medical Staff continuously evaluates competency and professional performance practice trends that impact patient safety and / or quality of patient care.

3. Credentialing Committee (CC): A multidisciplinary medical staff committee responsible for managing the evaluation process for all credentialed practitioners granted clinical privileges.

4. Practitioner: Member of the medical or allied health professional staff that has been granted clinical privileges.

5. Professional Practice Evaluation / Evaluation Process: The period or process of either a focused or ongoing evaluation of competency and professional performance for practitioners granted clinical privileges.

III. PROCEDURE

A. General Procedures

1. The Quality Department is responsible for monitoring and maintaining compliance with this policy.

2. Adverse results and recommendations from the Quality Department shall be forwarded to the Medical Executive Committee (MEC). Recommendations may include moving forward with OPPE, extending the period of FPPE or recommending to limit, suspend or revoke the privileges requested.

3. The MEC's recommendation shall be forwarded to the Board of Managers for final action.

4. Lack of adverse findings shall result in immediate approval of the requested privilege(s).

5. External resources may be utilized involving evaluations that raise concerns regarding potential conflict of interests or the lack of the necessary specialty or appropriate level of experience / skill.

B. Focused Professional Practice Evaluation (FPPE)

1. FPPE shall be for a time-limited period not to exceed six (6) months. This will include the evaluation of at least six (6) patients. FPPE shall be performed under the following circumstances:
   a. New practitioners with initially granted privileges
   b. Current practitioners requesting modification of existing privileges and/or privileges to perform new or rarely performed procedures
   c. When questions and / or concerns are raised through either the OPPE process, individual case review or other peer review process regarding a practitioners competency or professional performance that may affect the provision of safe, high quality patient care.

2. FPPE may be obtained from the practitioner's own practice manager as indicated on the attached the THSL Competency Attestation form.

3. Upon the conclusion of the FPPE process, each practitioner will automatically be placed on OPPE following the next scheduled Credentialing Committee, Medical Executive Committee and Board of Managers meetings if all requirements are met.

4. If any requirement is not met, and requires specific action by the practitioner, written or electronic notice will be sent.

5. The practitioner is not entitled to hearing and appeal or other procedural rights for any privilege that is voluntarily relinquished.

6. Monitoring criteria, including specific performance elements, thresholds and / or triggers, are developed and approved by the medical staff or Credentialing Committee. Triggers are defined as potentially unacceptable levels of performance. Triggers may include, but are not limited to:
   a. A sentinel event
   b. A single egregious case or evidence of a practice trend
   c. Exceeding the predetermined thresholds established for OPPE
   d. Verified patient / staff complaints
   e. Non-compliance with Medical Staff Bylaws, Rules & Regulations and / or Hospital Policies & Procedures
   f. Elevated infection, mortality and / or complication rates
   g. Failure to follow established clinical practice guidelines
   h. Unprofessional and / or disruptive behavior

C. Ongoing Professional Practice Evaluation (OPPE)

1. OPPE shall begin immediately following satisfactory completion of the FPPE process. Ongoing evaluation shall be performed and reported at least every six

(6) months for the purpose of assessing a practitioner's clinical competence, professional behavior and to identify professional practice trends that impact quality of care and patient safety. Ongoing evaluation is incorporated into the review and recommendation process for approval of maintaining existing privileges, modifying existing privileges or to limit, suspend or revoke existing privilege(s) prior to and / or at the time of reappointment.

3. In the event a practitioner's activity has not been sufficient to meet OPPE requirements, he / she may:
   a. Voluntarily resign; or
   b. Obtain current competency attestation.

4. Thresholds / triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable levels of performance within the established defined criteria and are used to identify those performance outcomes that could trigger FPPE. Triggers may include, but are not limited to:
   a. A sentinel event
   b. Defined number of events occurring
   c. Defined number of individual peer reviews with adverse determinations
   d. Elevated infection, mortality and / or complication rates
   e. Increasing lengths of stay in comparison to peers
   f. Increasing number of returns to surgery
   g. Frequent unanticipated readmission for the same issue
   h. Patterns of unnecessary utilization of diagnostic testing / treatments
   i. Failure to follow established clinical practice guidelines
   j. Non-compliance with Medical Staff Bylaws, Rules & Regulations and / or Hospital Policies & Procedures

5. The results of the individualized practitioner report(s) are referenced in the respective medical staff committee minutes and maintained in the practitioner’s file.

THSL Practitioner Competency Attestation.pdf