MSHRM MICHIGAN SOCIETY OF HEALTHCARE RISK MANAGEMENT

Professional Practice Evaluation: A Look Into One Critical Access Hospital's Peer Review Program

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Conflict of Interest Disclosure

Kristen L. Rifenbark does not have any real or apparent conflict(s) of interests or vested interest(s) that may have a direct bearing on the subject matter of the continuing education activity.

Learning Objectives

This presentation will enable participants to:

1. Describe the requirements of The Joint Commission's Professional Practice Evaluation standards.
2. Illustrate how Scheurer's Professional Practice Evaluation (PPE) Program works.
3. Describe how the PPE process compliments an Enterprise Risk Management Program.

Acronyms

- ACGME – American College of Graduate Medical Education
- ASHRM – American Society for Healthcare Risk Management
- CAH – Critical Access Hospital
- CoPs – Conditions of Participation
- COS – Chief of Staff
- CRNA – Certified Registered Nurse Anesthetist
- ED – Emergency Department
- EP – Elements of Performance
- ERM – Enterprise Risk Management
- FPPE – Focused Professional Practice Evaluation

Acronyms, continued

- HFAP – Healthcare Facilities Accreditation Program
- MEC – Medical Executive Committee
- NP – Nurse Practitioner
- OPPE – Ongoing Professional Practice Evaluation
- PA – Physician Assistant
- PPE – Professional Practice Evaluation
  - Name Alert ~ NOT Personal Protective Equipment
- QI – Quality Improvement Department
- SD – Standard Deviation
- TJC – The Joint Commission

Poll Questions

- Raise your hand if you have an established PPE program.
- Raise your hand if you are a critical access hospital.
- Raise your hand if PPE is your favorite!

Background

- 25 bed Critical Access Hospital (CAH)
  - Note: All standards I'll describe are for CAHs
- Approximately 130 members on our Medical Staff
  - Includes 50ish teleradiologists
- Active Staff and Medical Executive Committee (MEC) Composition
  - 1 pediatrician
  - 6 family practice
  - 1 internist
  - 1 radiologist
- 2 full time Certified Registered Nurse Anesthetists
  - No Anesthesiologists

Objective # 1

Describe the requirements of The Joint Commission's Professional Practice Evaluation standards.

The Joint Commission Standards July 2017

- MS.06.01.05
  - The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.
- MS.08.01.01
  - The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.

The Joint Commission Standards July 2017, continued

- MS.08.01.03
  - 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.
- MS.09.01.01
  - The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence.

Healthcare Facilities Accreditation Program Standards 2017

- Chapter 5, Staffing
  - 05.01.28 – Ongoing Professional Practice Evaluation (OPPE)
  - 05.01.29 – Focused Professional Practice Evaluation (FPPE)

Objective # 2

Illustrate how Scheurer's Professional Practice Evaluation (PPE) Program works.

PPE and Peer Review

- Our "hard core" PPE program started in April, 2011
- Previously had physician profiles
- Previously had a Peer Review process for "problem" cases
- No routine chart review
  - Exception: Physician Assistants (PA) and Nurse Practitioners (NP)

Responsibilities

- Oversight
  - Medical Executive Committee
  - Who ultimately "owns" PPE? (MS.09.01.01, EP 1)
- Coordination
  - Quality Improvement Department – in policy
  - Risk Management – in practice
- All Medical Staff
  - In Bylaws
  - In contracts

Areas of Core Competency

- From Accreditation Council for Graduate Medical Education (ACGME) (MS.06.01.05, EP 8)
- Patient Care
- Medical/Clinical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
  - TJC – Diversity statement – MS.06.01.03
- System-Based Practice

Focused Professional Practice Evaluation

- New Practitioners (MS.08.01.01, EP 1)
- New Privileges (MS.08.01.01, EP 1)
- Return from Leave of Absence
  - Who tracks this?
- OPPE Identifies a Need (MS.08.01.01, EP 6)

FPPE, continued

- Monitoring Period (MS.08.01.01, EP 3)
  - Date practitioner has activity thru end of current eval period
- Criteria for Reviews (MS.08.01.01, EP 3 & 5)
  - Spelled out in policy
- QI Request Reviews
  - For significant concerns identified by QI

Ongoing Professional Practice Evaluation

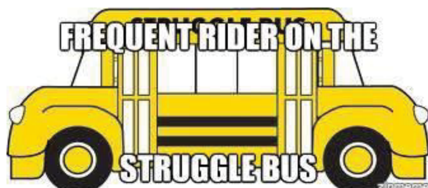
- Every 6 months
  - TJC = at least every 9 months/more frequently than annually
  - HFAP =at least 3 times during the two-year appointment cycle
- OPPE or FPPE but not both
- Monitoring (Introduction to standard MS.08.01.03)
  - Retrospective chart review
  - Clinical measures
  - Complaints

Evaluation

- Chief of Staff reviews findings from OPPE and FPPE
  - The Practitioner Profile
  - Determines if practitioner demonstrates competency for clinical privileges granted (MS.08.01.03, EP 1)
    - MEC is informed and approves
    - The practitioner is informed
  - Does not demonstrate competency or has not had enough volume to eval (MS.08.01.01, EP 6 & MS.08.01.03, EP 3)
    - COS documents action plan
    - Takes to MEC for decision
    - The practitioner is informed

The Struggle Bus is Real!

- Low or No Volume
- For PPE – use your own data and information (Intro to MS.08.01.01)
- For Credentialing – use your data and others' data (MS.08.01.03, EP 3)



Low/No Volume Providers

- Review continues for another 6 months
- Two year privilege period (MS.08.01.03, EP 3)
  - MEC determines if privileges should be granted again
  - May use info from other hospitals/facilities

Practitioner Profiles

- Used at reappointment time (MS.08.01.03, EP 3)
- Given to Medical Staff Office to include in privileging packet

Sample Practitioner Profile – Family

Practitioner Profile Report

Provider:
Specialty: Family Practice/Active

Period: 4.1.2016 - 9.30.2016
On Staff:
Term Date: -

Activity Report	Provider's Data
Inpatient Admissions - Attending	26
Observation Admissions - Attending	31
Swing Bed Admissions - Attending	17
Hospice/Respite Admissions - Attending	0
Primary Care Visits (Hospital Practices only)	3,383
Moderate to High Risk Procedures Performed within the Hospital	1
Procedures Performed within Hospital Practice	11

Patient Care	Indicator Type	Provider's Data	Peer Group Average
# of Routine Peer Review cases assigned Level 1 - No Concern	Review	9	94%
# of Routine Peer Review cases assigned Level 2 - Minor Concern	Review	0	2%
# of Routine Peer Review cases assigned Level 3 - Major Concern	Review	0	0%
# of Expedited Peer Review cases assigned Level 1 - No Concern	Review	1	0%
# of Expedited Peer Review cases assigned Level 2 - Minor Concern	Review	1	3%
# of Expedited Peer Review cases assigned Level 3 - Major Concern	Review	0	0%
Blood Usage - Units meeting reason to order criteria / total units given (includes PRBC, PLT, FFP, Autologous, Albumin)	Rate	100% (20)	100% (172)
Inpatient readmission within 30 days with same/similar diagnosis	Rate	15.38% (4/26)	3.4% (176)
Procedural Complications (Hospital Practice)	Rate	0%	0% (586)
PAP Specimens Satisfactory for Evaluation (Hospital Practices only)	Rate	87.5% (7/8)	96.9% (262)
Surgical/Procedural Complications performed within the Hospital - Minor	Rate	0.00%	0.07% (Surgeons) 0% (Attending Physicians) 0% (CRNAs)
Surgical/Procedural Complications performed within the Hospital - Significant	Rate	0.00%	0.14% (Surgeons) 0% (Attending Physicians) 0% (CRNAs)

Medical/Clinical Knowledge	Indicator Type	Provider's Data	Peer Group Average
Pneumonia - Antibiotic Selection	Rate	100% (2)	100% (17)
Heart Failure - Evaluation of LVS Functions	Rate	NA	100% (2)
Inpatient Influenza Immunization	Rate	NA	NA this period
Inpatient Pneumococcal Immunization	Rate	90.9% (20/22)	84.7% (118)
Communication and Interpersonal Skills	**Indicator Type**	**Provider's Data**	**Peer Group Average**
# of formal patient complaints related to practitioner's interactions	Rule	0	4 complaints/80 practitioners
Practice-Based Learning & Environment	**Indicator Type**	**4.1.16 - 9.30.16**	**Yearly Requirement* (Active)**
Required Meeting Attendance	Rate	100%	60%

Professionalism	Indicator Type	Provider's Data	Peer Group Average
# of validated incidents of disruptive practitioner behavior	Rule	0	0
System Based Practice	**Indicator Type**	**Provider's Data**	**Peer Group Average**
Suspensions for delinquent medical records	Rule	0	0
Average Inpatient Length of Stay	Rate	3.0 days	3.0 days (529 days/176 patients)
Average Swing Bed Length of Stay	Rate	10.2 days	12.5 days (876 days/70 patients)
Average Hospice/Respite Length of Stay	Rate	NA	4.1 days (29 days/7 patients)

Sample PPE Sign Off Form

Professional Practice Evaluation Sign Off

Provider:
Specialty: Family Practice/Active

Period: 4.1.2016 - 9.30.2016
On Staff:
Term Date: -

❑ Focused Professional Practice Evaluation (90-180 day review)

☑ Ongoing Professional Practice Evaluation Process

I, on behalf of the Medical Executive Committee, have completed an evaluation to the best of my ability and based on the information provided to me regarding this practitioner's professional performance in the six areas of general competencies:

- Medical Knowledge
- Patient Care/Clinical Judgment
- Interpersonal/Communication Skills
- Professionalism
- Systems Based Practices
- Practice Based Learning and Improvement

RECOMMENDATIONS:
Our evaluation is that this provider:

- ❑ 1. Demonstrates competency for the clincal privleges granted.
- ❑ 2. Demonstrates competency for the clinical privileges granted except the following:

- ❑ 3. Has not had enough volume to adequately evaluate performance and needs and additional six (6) month period for evaluation.

ACTION PLAN (FOR RECOMMENDATION 2 OR 3 ABOVE):

Signature (Chief of Staff) Date

3 Standard Deviations

Peer Group Average	Range in peers	3SD -/+	
100% (172)	100%	100%	All within 3SD
3.4% (176)	0-19.2%	0-14.1%	One oustide 3SD DR JOHN DOE 5 of 26 (19.2%)
0.4% (3296)	0-2.3%	0-3%	All within 3SD
99 minutes (179)	84-141 (with >5 in sample)	0-169	All within 3SD
13 minutes (207)	8-18 (with >5 in sample)	0-26	All within 3SD

Inpatient Readmissions

Your Turn!

- What “easy” measures can you use?
  - Mandated measures
  - Attendance
  - Customer complaints
- Remember…zero (0) is a value!

Your Turn!

- Write down 3-5 people you can gather information from.
- Ideas
  - Customer Service
  - Quality Improvement
  - Medical Records
  - Medical Staff Office
  - Human Resources

Types of Case Review – Routine

- Retrospective Chart Review 5 cases for most
- CRNA
  - Mix of type of anesthesia
  - Procedures inside and outside the OR
  - Reviewer = another CRNA

Types of Case Review – Routine, continued

- Emergency Department
  - Mix of patient age and high risk diagnoses
  - I.e. asthma, diabetes, COPD, CHF, pneumonia, abdominal or chest pain, fever in children, etc.
  - Reviewer = Board certified ED to board certified ED or internal med/family practice to internal med/family practice
- Inpatient, observation, Long Term Care
  - 5 cases total, at least one from each service, if available
  - Mixed ages and high risk diagnoses
  - Reviewer = Internal med/family practice to internal med/family practice

Types of Case Review – Routine, continued

- Surgeons
  - Mix of inpatient/outpatient procedures, varying ages and types of procedures, high risk
  - Reviewer = physician within same specialty i.e. general surgeon to general surgeon

Types of Case Review – Routine, continued

- Blood Utilization
  - All units are reviewed each quarter
  - Outside criteria, as determined by Medical Director, sent to ordering practitioner for more comments
  - Medical Director determines level of concern
- Clinics
  - 5 cases = 1 child and 4 adults
  - High risk diagnoses i.e. COPD, asthma, diabetes, CHF, well-child visits
  - Reviewers = midlevels to midlevels and physicians to physicians

Types of Case Review – Routine, continued

- Radiology
  - 20-25 cases of mixed modalities
  - Selected randomly Diagnostic Imaging Department
  - External reviewer due to only one radiologist on staff
- Coming to a hospital near you, Trauma Reviews!

Types of Case Review – Expedited

- Chart reviews
- Patient or staff concerns relating to quality of care (MS.09.01.09, EP 1 & EP 2)
  - If referred from patient or staff = COS review to determine if it qualifies
  - If referred from another Medical Staff member, Hospital President or QI System Leader no COS review needed
- Sentinel Event
- OPPE suggests reason for concern (MS.08.01.01, EP 2 and MS.08.01.01, EP 5)
- QI Committee reviews not meeting criteria
  - I.e. inpatient readmissions, returns to ED, etc.

Case Reviews

- Completed in a "timely" manner
  - Usually 2 weeks to 1 month
- Coordinated by QI staff
- Results are recorded in the period in which the review was completed

Example – Results Recorded in Period Received

	Start	End
PPE Round 1	10.1.2016	3.31.2017
PPE Round 2	4.1.2017	9.30.2017
Case # 105 Peer Review	3.17.2017	5.5.2017
Case # 105 Recorded in PPE Round 2 Profile		

Case Reviews, continued

- 3 level rating system
  - Level 1 – No Concern
    - Case managed and documented properly.
  - Level 2 – Minor Concern
    - A. Case was managed appropriately, but documentation not adequate.
    - B. Medical management deviated from the norm, but not likely to cause a significant adverse outcome.
  - Level 3 – Major Concern
    - Medical management deviated from the norm and likely contributed to a significant adverse outcome or had the potential to contribute to a significant adverse outcome.
- Most valuable – comments!

Example – OPPE to FPPE Case

Peer Review Protections

- All forms are stamped with Peer Review statutes
- MEC meetings – PPE is separated
- Profiles and chart reviews kept in QI file
  - Only available to those who have a need to know

Professional Practice Evaluation aka Peer Review

Professional Practice Evaluation aka Peer Review

Tips and Recommendations

- Keep it simple
- Continually improve
- Automate as much as possible
- Seek support and assistance from others

Easy Peasy!

Objective # 3

Describe how the PPE process compliments an Enterprise Risk Management Program.

Enterprise Risk Management

- According to ASHRM
- "Enterprise Risk Management (ERM) in healthcare promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value."
- 8 domains

Operational	Human Capital
Clinical/Patient Safety	Legal/Regulatory
Strategic	Technology
Financial	Hazard

Operational

- Adverse Event Management
- Credentialing and staffing
- Documentation
- Chain of command
- Deviation from practice

Clinical/Patient Safety

- Delivery of care
- Evidence based practices
- Medication errors
- Hospital acquired conditions
- Serious safety events

Strategic

- Brand, reputation, competition
- Failure to adapt to changing times
- Health reform or customer priorities

Financial

- Malpractice
- Litigation
- Insurance
- Growth in programs and facilities
- Corporate compliance (fraud and abuse)

Human Capital

- Employee recruitment and selection, retention, turnover
- Staffing
- Absenteeism
- Fatigue
- Productivity

Legal/Regulatory

- Local, state and federal levels
- Licensure
- Accreditation
- CMS Conditions of Participation (CoPs)

Technology

- Clinical diagnosis and treatment
- Training and education
- Electronic Health Records
- Meaningful Use

Hazard

- Assets and their values
- Emergency Preparedness
- Emergency Credentialing including PPE (EM.02.02.13, EP 7)

Objectives

Now, are you able to:

1. Describe the requirements of The Joint Commission’s Professional Practice Evaluation standards.
2. Illustrate how Scheurer’s Professional Practice Evaluation (PPE) Program works.
3. Describe how the PPE process compliments an Enterprise Risk Management Program.

Questions?

Thank you!

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