UCLA Ronald Reagan Medical Center

Professional Practice Evaluation MS 120

Manual	Medical Staff	***Effective Date***	05/31/2007
Policy #	MS 120	***Date Revised***	06/30/2010
Responsible Person	Director, Medical Staff Services	***Next Scheduled Review***	06/30/2022

Purpose

To define Medical Staff policies and procedures related to professional practice evaluation processes including peer review, the development and implementation of an Ongoing Professional Practice Evaluation (OPPE) program and the initiation of a Focused Professional Practice Evaluation (FPPE).

Definitions

1. Data – Data means aggregate measurements related to Events, clinical outcomes, steps in the performance of a clinical process, or other aggregate information related to the clinical performance, behavior, and/or professionalism of a medical staff member at Ronald Reagan UCLA Medical Center (RRUCLAMC).

2. Event – Event means an undesirable or unexpected clinical and/or behavior-related occurrence identified by the organization at RRUCLAMC. Information regarding Events may be aggregated and considered Data.

3. First Level Assessment – A primary review of Data or Events by the Service Chief or designee. The purpose of First Level Assessment is to determine if an opportunity for improvement exists and/or if further review or Focused Professional Practice Evaluation is required to understand the significance of the Data or Event.

4. Focused Professional Practice Evaluation – The process whereby the Medical Staff evaluates privilege-specific competencies of a medical staff member. A Focused Professional Practice Evaluation shall be initiated when questions arise regarding the ability of a currently credentialed member to provide safe, high-quality patient care services to patients at Ronald Reagan UCLA Medical Center (RRMC)

5. Investigation – A formal review action which may be initiated by the Medical Staff Executive Committee (MSEC) as described in Article VII of the Medical Staff Bylaws. An Investigation is initiated when reliable information indicates that a Medical Staff Member may have exhibited acts, demeanor, or conduct reasonably likely to be, among others:
    a. Detrimental to patient safety or to the delivery of quality patient care within the Medical Center.
    b. Unethical or unprofessional
    c. Contrary to the Medical Staff Bylaws, Rules and Regulations
    d. Below applicable professional standards.
    e. Disruptive of Medical Staff or Medical Center operations
    f. Breach of privacy and confidentiality

6. Ongoing Professional Practice Evaluation – The program developed by the Medical Staff to assure the continuous monitoring of the professional practice of its members. Through the Ongoing Professional Practice Evaluation program, the Medical Staff monitors Events and Data related to members' clinical performance, behavior, and professionalism that are important indicators of quality and patient safety at RRUCLAMC.

7. Peer Review Committee – A Medical Staff committee assigned authority by the Medical Staff Executive Committee to make judgments regarding the appropriateness of a Medical Staff member's clinical performance, behavior, and/or professionalism as related to expected clinical standards of care and/or professional behavior at RRUCLAMC. Any Hospital or Medical Staff sponsored committee or group may make suggestions or recommendations to a Medical staff member regarding alternatives to care and/or

provide evidence-based information regarding best practice, but only Peer Review Committees can make Peer Review Conclusions regarding a Medical Staff member. At RRMC Peer Review Committees include:

a. The Medical Staff Executive Committee, or;
b. The Credentials Committee; or
c. The Peer Review Committee; or
d. A Clinical Service Performance Improvement Committee (Dept M&M), or;
e. An ad hoc Medical Staff committee assigned peer review authorization by the Medical Staff Executive Committee.

Policy

1. All clinical services provided by members of the Medical Staff shall be reviewed both as part of the Medical Center's Performance Improvement and Patient Safety program as described in the Medical Center's Performance Improvement and Patient Safety Plan and as part of the Medical Staff's peer review program as defined in Medical Staff Policy and Procedure MS 102: Quality Management and Peer Review.

2. The Medical Staff encourages patients, families, and Hospital staff to provide the Hospital with information or concerns regarding any member's clinical performance, behavior, and/or professionalism that may be related to the provision of quality patient care services at RRMC. Any such information or concerns shall be clearly reported via the on-line Event Reporting System or through Patient Relations (Reference Hospital Policies HS 0328 – Event Management and HS9417 – Patient Complaints)

3. Each Clinical Service Chief of the Medical Staff shall perform monitoring and assessment functions related to Ongoing Professional Practice Evaluation Events and Data, and make assessments related to their member's performance.

4. In order to perform these Ongoing Practice Professional Practice Evaluation assessments, each Clinical Service must establish minimum Medical Staff clinical activity requirements, designating a minimum number of cases to be performed at RRUCLAMC by members of the Service.

5. Each Clinical Service of the Medical Staff is required to develop peer review and quality assessment criteria that describe those outcomes, care processes, and events which will be measured and assessed by the service. Event and Data information will be assessed at both the aggregate and member-specific level. The surveillance program may include monitoring of the following elements when appropriate:
    a. Medical Staff approved generic indicators.
    b. Service-specific clinical indicators or outcome measurements.
    c. Morbidity and mortality rates.
    d. Compliance with standards of evidence-based medicine.
    e. Outcomes of operative and other clinical procedures.
    f. Practitioner-specific practice patterns related to ordering tests and procedures.
    g. Practitioner-specific practice patterns related to blood and medication use.
    h. Practitioner-specific practice patterns related to the use of consultants.
    i. Practitioner-specific practice patterns related to length of stay.
    j. Evidence-based clinical process audits.

6. Ongoing Professional Practice Evaluation information may be acquired through, but is not limited to, information from the following sources:
    a. Review of unexpected occurrences.
    b. Periodic chart review.
    c. Direct observation of procedures and patient care interventions.
    d. Proctoring.
    e. Discussion with others involved in the care of the patient

7. The Clinical Service Chief will additionally review referrals from the following sources:
    a. Clinical occurrences reported by the Hospital Risk Manager.
    b. Sentinel event information identifying member-specific clinical concerns.
    c. Staff observations or concerns related to a member's clinical skill and performance.
    d. Patient or family observations, concerns or complaints related to a member's clinical skill and performance.
    e. Legal cases identified by the Hospital which may relate to a member's clinical skill and performance.
    f. Referrals from other Medical Staff committees or groups related to a members clinical skill and performance.
    g. Referrals from external agencies related to a member's clinical skill and performance.
    h. Other Event and/or Data information as determined by the Medical Staff Executive Committee, Service, and/or Peer Review chairperson.
    i. Other information or events reported to the Clinical Service Chief.

8. The Clinical Service Chief will review identified concerns related to:
    a. Behavior and/or professionalism-related occurrences or concerns reported by the Hospital Risk Manager.
    b. Patient or family complaints or concerns related to Member-specific behavior and/or professionalism issues.
    c. Referrals from other committees or groups related to Member-specific behavior and/or professionalism concerns.
    d. Identified concerns related to disruptive or unprofessional behavior including sexual harassment.
    e. Possible failure of a Member to follow Medical Staff bylaws, rules and regulations, or policies ("Medical Staff Policies") or to follow Hospital policies.

9. When assessment of Events or Data from the Medical Staff Ongoing Professional Practice Evaluation program identifies concerns regarding a currently privileged Member's ability to provide safe, high-quality patient care services, a Focused Professional Practice Evaluation shall be initiated by the Medical Staff. The purpose of the Focused Professional Practice Evaluation is to determine if the quality of patient care services and/or the behavior of a Member meet the standards which have been established by the Medical Staff at RRMC.

10. A Focused Professional Practice Evaluation may be initiated in the following circumstances:
    a. Member-specific, clinically significant and statistically significant, undesirable outcome variations have been noted.
    b. Recurrent episodes of unacceptable variation related to clinical care processes.
    c. The identification of recurrent episodes of disruptive and/or unprofessional behavior.
    d. Member-specific involvement in a clinically significant unexpected adverse Event resulting in death or permanent injury to a patient where the cause of the Event has been determined by the Medical Staff to be related to a Member's clinical performance or behavior.
    e. Ongoing zero patient care activity prior to the expiration of appointment.

11. First Level Assessments and Focused Professional Practice Evaluations are not considered final and verified actions of the Medical Staff and are not considered an "Investigation" for purposes of reporting Medical Staff activities related to disciplinary actions as described in applicable federal and state licensing reporting requirements.

Procedure

1. If concerns are identified by any committee, service, division, or staff member in the organization regarding the clinical performance, behavior, and/or professionalism of a Member, that concern will be forwarded to the appropriate Clinical Service Chief for review as described in this policy.

2. Other Ongoing Professional Practice Evaluation quality management data, as described in the Policy Sections 1 through 7, will be collected by the Quality Management Department and submitted to the appropriate Clinical Service Chief for review. These Ongoing Professional Practice Evaluation measures shall be consistently implemented, applied to all appropriate Practitioners, and assessed in a fair and reasonable manner. Assessment information related to these measurements shall be used by the Medical Staff to resolve performance issues whenever reasonably possible.

3. The Clinical Service Chief may evaluate the quality management information submitted for review and determine that no action is indicated or that an action is indicated which does not necessarily require direct discussion with and/or comments from the involved Member.

4. When a Focused Professional Practice Evaluation is initiated, the following events shall occur:
    a. The involved Member will be given both verbal and written notice by the Clinical Service Chief or designee regarding the specific concerns which have been identified and are the basis of initiating the Focused Professional Practice Evaluation.
    b. The involved Member will be given access to medical records and other appropriate information necessary to respond to the cases or events. "Appropriate information" does not include access to Event Reports but rather a summary of the issue reported on the Report if such information is relevant to the cases or events under review.
    c. The Peer Review Committee performing a Focused Professional Practice Evaluation may be a standing Peer Review Committee or an ad hoc Peer Review Committee assigned authority by the Chief of Staff or a Peer Review Committee chairperson.
    d. Prior to reaching a final conclusion, the Peer Review Committee shall allow the involved Member to respond to the committee's concerns either in writing or by addressing the Peer Review Committee in person. The involved Member shall be strongly encouraged to submit a written response to all identified clinical concerns.
    e. The Member being reviewed has the right to address the Peer Review Committee in person if he or she so desires. If the involved Member does not wish to address the Peer Review Committee, in writing or in person, this fact shall be noted by the Peer Review Committee chairperson and recorded in the Peer Review Committee’s minutes.
    f. The Peer Review Committee may require the attendance of the involved Practitioner at a Peer Review Committee meeting.
    g. A report of the conclusions of any ad hoc Focused Professional Practice Evaluation committee will be reported to the appropriate delegating committee.
    h. The findings and conclusions of the Focused Professional Practice Evaluation shall be reported to the Medical Staff Executive Committee by the appropriate Peer Review Committee chairperson or designee at the next regularly scheduled Medical Staff Executive Committee meeting.

5. If a Peer Review Committee conducting any type of peer review evaluation, included a Focused Professional Practice Evaluation, requests that the involved Practitioner provide additional information to the Peer Review Committee either in writing or through a personal appearance, it shall be the obligation of the Practitioner being reviewed to fulfill this request within a reasonable period of time as may be established by the Peer Review Committee. When additional information or a personal appearance is requested, failure of the Practitioner being reviewed to comply with the request of the Peer Review Committee shall be considered a violation of Medical Staff Bylaws, and will result in automatic

suspension of the Practitioner's clinical privileges pursuant to Medical Staff Bylaws. The automatic suspension shall remain in effect until the Peer Review Committee's request is met.

6. When the concerns being reviewed include clinical or technical issues related to a specific specialty treatment or procedure, the Peer Review Committee should include at least one peer who is a Member currently qualified and competent in the clinical area, specific treatment or procedure under discussion. This provision does not apply to peer review related to disruptive and/or unprofessional behavior.

7. The chairperson of a Peer Review Committee shall consider the use of external peer review consultation when either there are no Members available to serve on the Peer Review Committee who have appropriate clinical or technical skills, or when there is a potential for significant conflict of interest.

8. A Focused Professional Practice Evaluation should be completed within 120 days of initiation whenever reasonably possible. If the Peer Review Committee is not able to complete the Focused Professional Practice Evaluation within 120 days of initiation, a report will be submitted to the Medical Staff Executive Committee regarding the status and timeliness of the Focused Professional Practice Evaluation.

9. The conclusions of a Focused Professional Practice Evaluation shall be recorded in writing and shall include a record of any medical record reviews, interviews, reports, medical literature information utilized, relevant clinical practice guidelines and/or evidence-based information which has been used in arriving at the Peer Review Committee's conclusions and recommendations. The recommendations shall include consideration of the need for corrective action, education, additional performance monitoring (internal or external), and/or other actions as deemed appropriate by the Peer Review Committee.

10. If a Focused Professional Practice Evaluation or other peer review activity results in findings and conclusions which are adverse to the member and include a recommendation for corrective action which would generate hearing rights as described in the Medical Staff Bylaws, the Medical Staff Executive Committee should consider the initiation of an Investigation pursuant to Article VII the Bylaws prior to taking such a disciplinary action. The Medical Staff Executive Committee has no obligation to implement the recommendations of any Peer Review Committee and nothing in this policy shall interfere with the right of the Medical Staff Executive Committee to initiate disciplinary action without the initiation of an Investigation.

APPROVALS

Medical Staff Executive Committee:	06/27/2013 and 6/30/2019 reviewed with no revisions
Governing Body:	06/30/2013 and 6/30/2019 reviewed with no revisions